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Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

WHAT HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN BELGIUM?

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WHAT HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN BELGIUM?

DOMINIQUE ROBERFROID, MARIE DAUVRIN, INES KEYGNAERT, ANJA DESOMER, BIRGIT KERSTENS, CÉCILE CAMBERLIN, JULIE GYSEN, VINCENT LORANT, ILSE DERLUYN

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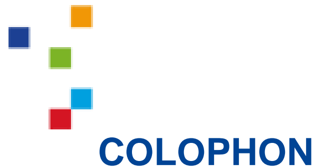
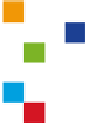


COLOPHON

Title:	What health care for undocumented migrants in Belgium?
Authors:	Dominique Roberfroid (KCE), Marie Dauvrin (UCL), Ines Keygnaert (ICRH-Universiteit Gent), Anja Desomer (KCE), Birgit Kerstens (Universiteit Gent), Cécile Camberlin (KCE), Julie Gysen (UCL), Vincent Lorant (UCL), Ilse Derluyn (Universiteit Gent)
Project director:	Dominique Paulus (KCE)
Reviewers:	Laurence Kohn (KCE), Christian Léonard (KCE), Karin Rondia (KCE)
Stakeholders / external experts:	Stéphan Alongi (GHDC), Loranci Anamdarajah (Dokters van de Wereld), Ludwig Apers (ITG), Hervé Avalosse (Alliance Nationale des Mutualités Chrétiennes), Hicran Aydogdu (CPAS Molenbeek Saint-Jean), Alain Back (CPAS Bruxelles), Christophe Barbut (Maison médicale "Enseignement"), Patricia Barlow (CHU St Pierre), Els Bartholomeeusen (VWGC vereniging wijkgzondheidscentra), Jeroen Berens (K&G), Mia Beyaert (AZ Groeninge Kortrijk), Yannick Bizack (CPAS Molenbeek Saint-Jean), Sophie Bleus (Médecins du Monde), Alain Brousmiche (CPAS Charleroi), Alexandra Büchler (Myria), Begoña Cainas (CHU St Pierre), Kelly De Ceulaer (K&G), André Cocle (Réseau hospitalier IRIS), Caroline Colinet (Maison médicale des marolles), Veerle Cortebeeck (VVSG), Fabienne Crauwels (VVSG), Karen Crauwels (OCMW Antwerpen), Sophie Damien (Médecins du Monde), Mikael Daubie (INAMI), Laurence Dauginet (CAAMI), Janne Debaere (AZ Jan Palfijn), Tina De Boeck (Kind & Gezin), Nadine de Buck (CPAS Saint-Gilles), Stephanie De Clercq (AZ Jan Palfijn), Noël de Coster (CPAS Saint-Gilles), David De Keukelaere (OCMW Gent), Pierre De Proost (CPAS Molenbeek Saint-Jean), Ri De Ridder (RIZIV), Dominique Decoux (CPAS Schaerbeek), Jeaninne De Decker (CPAS Saint-Gilles), Stéphane Degesves (CHR Citadelle), Marylène Delhaxhe (Sauveur ONE), Jozefien Demeester (Odice), Alix Dequiper (CPAS Liège), Laura Di Dominico (CHU Charleroi), Eric Dosimont (CPAS Charleroi), Eric Devilliers (ISPPC CHU Charleroi, CHU Vésale), Gert Devolder (WGC 't Spoor), Martine Devos (UVC Brugmann (IRIS-ziekenhuis)), Koen Dewulf (Myria), Brecht D'Hoore (Agentschap Integratie en Inburgering/Kruispunt M-I), Linda Doeraene (CHU St Pierre), Pierre Drielsma (FMM), Raphaël Driesen (CHR Citadelle), Judith Duchêne (UVCW), Alain Dupont (SPP Intégration sociale), Michelle Dusart (CHU St Pierre), Kristof Eeckloo (UZ Gent), Aline Egerickx (CPAS Schaerbeek), Carine Elst (CPAS Bruxelles), Claude Emonts (CPAS Liège), Marcel Engelborghs (CPAS Ixelles), Greet Erven (Dokters van de Wereld), Veerle Evenepoel (Medimmigrant), Louis Ferrant (Domus Medica), Patricia Fruyt (UZ Gent), Claire Gazottie (CHR Citadelle), Lode Geps (Dokters van de Wereld), Kurt Gesquière (POD Maatschappelijke integratie), Abdel Ghali (Universiteit Gent), Sofie Goderis (AZ Sint Lucas), Lucie Guerra (Maison médicale la Glaise), Stefanie Haerens (OCMW Kortrijk), Ana Hernandez (ONE), Stephane Heymans (Médecins du Monde), Joeriska Hillaert (AZ Groeninge, Kortrijk), Delphine Houba (CPAS Molenbeek Saint-Jean), Erna Houtman (Kind & Gezin), Eric Husson (LAMA asbl), Danielle Indovino (CPAS Liège), Odile Jacmain (Dispositif d'Accès Socio-Sanitaire), Kathy Jacobs (Kind & Gezin), Patrick Jadoulle (Maison médicale la Glaise), Jean-Marc Jalhay (CPAS Liège), Jacques Janssens (Maison médicale Entr'aide des Marolles), Stéphanie Jassogne (Medimmigrant), Irène Jusret (CHU



Charleroi), Dirk Kaekebeke (CPAS Schaerbeek), Masha Khaskelberg (TABANE), Robert Leach (Clinique Saint Jean), Christian Lejour (AVCB - Section CPAS), Benedicte Leloup (Wijkgezondheidscentrum De Brug, Molenbeek), Evy Lenaerts (Geneeskunde voor het Volk-groepspraktijk, Hoboken), Geneviève Lequeue (CPAS Ixelles), Alexandre Lesiw (SPP Intégration sociale), Corinne Loncin (CPAS Liège), Christine Louwagie (CPAS Schaerbeek), Sophie Magnee (CPAS Bruxelles), Taissa Majieva (UZ Gent), Martine Mardaga (Maison médicale du Laveu), Tina Martens (CPAS Molenbeek Saint-Jean), Benoit Mathieu Dabois (CPAS Bruxelles), Freddy Merckx (Wijkgezondheidscentrum De Brug, Molenbeek), Filippina Messina (CHU Charleroi), Martine Meulebroek (UZ Gent), Ariane Michel (UVCW), Christine Miclotte (CAAMI), Brigitte Missa (Centre de santé intégré de Tilleur), Fabienne Miroir (CPAS Anderlecht), Annemarie Moens (UZ Brussels), Pierre Mols (CHU St Pierre), Peter Moonen (OCMW Antwerpen), Yacine Ouafa (Dokters van de Wereld), Marie-Ange Paulus (CPAS Ixelles), Harold Peeters (CPAS Anderlecht), Laura Peeters (Universiteit Gent), Pascale Peraïta (CPAS Bruxelles), Dominique Pirard (ISPPC Charleroi), Rudy Pirard (CHR Citadelle), Tine Platteeuw (UZ Gent), François Poncin (Réseau Hépatite C asbl), Thierry Preseau (UVC Brugmann, IRIS-ziekenhuis), Inge Raus (GZA), Stéphane Roberti (CPAS Forest), Franc Rottiers (CAW Antwerpen), Cécile Rubay (CHU St Pierre), Jacques Rucquoi (CPAS Bruxelles), Jan Rymen (WGC Zuidrand), Latifa Sarguini (Maison médicale Kattebroek), Annie Schepens (Kind & Gezin), Eddy Schikorr (CPAS Anderlecht), Florence Simonis (Collectif de santé de Charleroi Nord), Caroline Simons (Geneeskunde voor het Volk-groepspraktijk, (Hoboken)), Jean Spinette (CPAS Saint-Gilles), Nathalie Sterckx (AVCB-VSGB), Philippe Taffin (CPAS Anderlecht), Laurence Theizen (Maison d'accueil Socio Sanitaire de Bruxelles), Berlinde Tillie (UVC Brugmann, IRIS-ziekenhuis), Amy To (Médecins du Monde), Christiane Tomat (CHR Citadelle), Inge Torfs (ZNA), Julien Trepagne (GHDC), Servaas Van Eeckhoudt (KULeuven), Kathia Van Egmond (Fedasil), Katrien Van Gelder (Asielbeleid Gent-vrijwillige terugkeer), Els Van Hooste (Wijkgezondheidscentrum Medikuregem, Anderlecht + Kind & Gezin), Géraldine Van Langenhove (Relais santé Charleroi), Geert Van Rasbeeck (CPAS Bruxelles), Sophie Van steene (CPAS Forest), Chantal Van Vaerenbergh (Kind & Gezin), Pierre-Yves Vandegeerde (POD Maatschappelijke integratie), Valerie Vandenberghe (OCMW Gent), Martine Vanderkam (CHU St Pierre), Juliette Vanderveken (Médecins du Monde), Kris Vanduffel (Stedelijk Opvanginitiatief, Gent), Bjorn Vanhie (OCMW Gent), Erik Vanobbergen (Geneeskunde voor het Volk-groepspraktijk, Hoboken)), Rita Vanobberghen (Médecine pour le peuple, Molenbeek Saint-Jean), Nele Verbist (Wijkgezondheidscentrum Medikuregem, Anderlecht), Anita Verbruggen (ZNA), Karen Vereycken (GZA), Francoise Verheyden (CPAS Ixelles), Annelies Vincent (OCMW Gent), Chantal Volant (CPAS Ixelles), Annika Waag (Odice), Marie Wastchenko (AVCB-VSGB), Danica Zamurovic (CAAMI)

External validators: David Ingleby (University of Amsterdam, the Netherlands), Majda Lamkaddem (Academic Medical Center, Amsterdam, the Netherlands), Jasna Loos (Institute of Tropical Medicine, Antwerpen)

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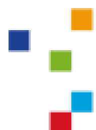

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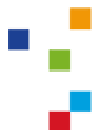

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[a] This chapter was authored by Ines Keygnaert (ICRH-UGent), Marie Dauvrin (UCL), Birgit Kerstens (UGent), Julie Gysen (UCL), Vincent Lorant (UCL), and Ilse Derluyn (UGent)

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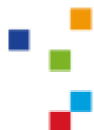
[b] This chapter was authored by Marie Dauvrin (UCL), Ines Keygnaert (ICRH-UGent), Birgit Kerstens (UGent), Julie Gysen (UCL), Ilse Derluyn (UGent), and Vincent Lorant (UCL)



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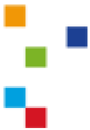

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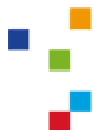


LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
ADH – HJA	Anonymised Days of Hospitalisation – Anonieme Daghospitalisaties – Hospitalisations de Jour Anonymisées
AIM – IMA	Inter mutuality agency – Agence Intermutualliste – InterMutualistisch Agentschap
BCSS – KSZ	Crossroads Bank for Social Security - Banque Carrefour de la Sécurité Sociale - Kruispuntbank van de Sociale Zekerheid
CAAMI – HZIV	Auxiliary Sickness & Invalidity Insurance Fund – Caisse Auxiliaire d'Assurance Maladie-Invalidité – Hulpkas voor Ziekte- en Invaliditeitsverzekering
CPAS – OCMW	Public Social Welfare Centre – Centre Public d'Action sociale – Openbaar Centrum voor Maatschappelijk Welzijn
DMG- GMD	Global Medical File – Dossier Médical Global – Globaal Medisch Dossier
EPS	Permanent sample – Echantillon permanent- Permanente Steekproef
HCP	Health care professionals and managers
INAMI – RIZIV	National Institute for Health and Disability Insurance – Institut National d'Assurance Maladie Invalidité – Rijksinstituut voor ziekte-en invaliditeitsverzekering
MESH	Medical Subject Heading
RHM – MZG	Minimal Hospital Summary – Résumé Hospitalier Minimum – Minimale Ziekenhuisgegevens
SPF Santé publique – FOD Volksgezondheid	Federal Public Service Health, Food Chain and Environment - Service Public Fédéral Santé publique, Sécurité de la Chaîne alimentaire et Environnement – Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu
SPP IS – POD MS	Federal Public Service of Programmation for Social Integration – Service Public fédéral de Pogrammation Intégration Sociale – Programmatorische federale Overheidsdienst Maatschappelijke Integratie
SWOT	Strenghts, Weaknesses, Opportunities, Threats
UM	Undocumented Migrants
UMA	Urgent Medical Aid

SCIENTIFIC REPORT

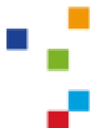
1 BACKGROUND

1.1 Who are the undocumented migrants?

Undocumented migrants[c] (UM) are individuals without a residence permit authorising them to regularly stay in Belgium. They include individuals who have entered the country irregularly, people whose residence status (e.g. visa, residence or work permit) has expired or become invalidated, those who have been unsuccessful in obtaining asylum, and those born to undocumented parents[1, 2]. Asylum-seekers and refugees are not undocumented migrants. In 2008 it was estimated that undocumented migrants amount to 7% - 13% of all foreign residents in the EU[3]. In Belgium, the regular foreign population was 1 214 605 on January 1 2014 (68% of whom are from the EU-28)[4], suggesting there would between 85 000 and 160 000 undocumented migrants, including migrants from the EU-28. This represents between 0.8% and 1.4% of the general population. Net migration to Belgium has been decreasing in recent years (from 84 997 in 2010 to 46 106 in 2013[4]). However, given the political crises in Syria, Iraq, Eritrea and Afghanistan, the number of documented and undocumented migrants will most likely rise in 2014 and 2015. UM have few legal entitlements, for instance they have no right to work. Regarding health care, they cannot be affiliated to a mutual health care and therefore they are not covered by the legal Belgian health insurance system[d]. They are however entitled to receive Urgent Medical Aid (UMA).

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

[d] The only other rights are: the right for minors to go to school; the right for clandestine workers to be paid a decent salary, to have a safe work and to receive a compensation in case of work accident; the right to start a lawsuit and to have a legal aid *pro deo* on matters relating to their undocumented situation; the right for indigent families with a minor to live in a welcome centre for 30 days, i.e. for preparing their return to the country of origin; and the right to mary. Moreover, children less than 6 year old have a free access to preventive care (including vaccinations) through the ONE/Kind & Gezin. Unaccompanied minors have the same access to health care than nationals provided they are registered in a school for at least 3 months.



1.2 What is Urgent Medical Aid?

Urgent Medical Aid (UMA) as described in the organic law of Public Centres for Social Welfare (CPAS – OCMW) (art 57 §2 of the law 8 July 1976)[5] and further defined in the Royal Decree of 12 December 1996[6] entitles UM to access health care. It is a medical aid (i.e. not a social or housing or pecuniary aid[e]) which urgency is evaluated and attested by a registered medical doctor (or dentist)[f] and only geared towards UM. Urgency is not defined by law but assessed by the health practitioner consulted. UMA can encompass any preventive and curative health care, delivered either in hospital or ambulatory settings, as well as drug prescription. UMA must be differentiated from the Emergency Medical Assistance, i.e. health care needed immediately for a life-threatening condition, which is specifically regulated by another law[7] and applies to everyone, including UM.

1.3 Why does UMA matter?

1.3.1 Human rights

Human rights are inalienable rights which guarantee the fundamental dignity of the human being. Guaranteeing the application of human rights for all on its territory is a legal duty of the State. Belgium ratified in 1983 the International Covenant on Economic, Social, and Cultural Rights[8] which states that health care is a human right that should be available to everyone within the jurisdiction of a state, without discrimination[g]. The charter of fundamental rights of the European Union in 2000 also emphasizes the right for everyone to benefit from medical treatment[h]. In 2004, Belgium ratified the European Social Charter[9] stipulating that the EU Member States should ensure that any person who is without adequate resources be granted adequate assistance, and, in case of sickness, the care necessitated by his/her condition[i]. The article 57 §2 of the organic law of CPAS – OCMW) (8

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e In case of hospitalisation, all costs are covered, including food and hospital stay

f The organic law of CPAS – OCMW of 8 July 1976 stipulated that all people have the right to social aid (either material, social, medical, medico-social or psychological), i.e. it did not differentiate Belgian citizens and foreigners. The law of 28 June 1984 modified the article 57 of the law of 8 July 1976 by limiting the social aid for undocumented migrants to the material and medical aid necessary to ensure their subsistence. The article 57 of the law of 8 July 1976 was replaced by the article 151 of the law of 30 December 1992 stipulating that undocumented migrants could receive only the necessary aid to allow them to leave the national territory, whereas an exemption was possible for urgent medical aid. The article 57 of the law of 8 July 1976 was modified a third time in 1996 to clarify the concept of urgent medical aid.

g Article 12 of the Covenant on Economic, Social and Cultural Rights

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

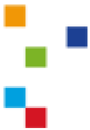
h Article 35 of the Charter of fundamental rights of the European Union

Health care

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.

i Article 13 of the European Social Charter

The right to social and medical assistance With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake: 1 to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition; 2 to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights; 3 to provide that everyone may receive by appropriate public or private services



July 1976)[5] and the Royal Decree of 12 December 1996[6] translate this commitment in the Belgian law and provide a legal frame for application.

The non-application of that right impacts directly and indirectly the health of UM. Legal restrictions on access to health care and administrative barriers lead to delayed care, and thus contribute directly to deteriorating the health status of UM[10-12]. The indirect effect comes from restrictive entitlements for UM being an "othering" process, i.e. a process of marginalisation, disempowerment and social exclusion[13]. Such actual and perceived discriminations may lead to psychosocial and physical morbidity[14-16].

1.3.2 Public health

Good primary care for early detection and treatment of illness has been accepted as a fundamental priority for health systems since the WHO's Declaration of Alma Ata (1978). Studies in other countries showed that UM usually present to health services at a late stage[11, 12]. Restricting or complicating access to health care may jeopardize the health of UM. Well organizing health care for UM is also relevant for public health as the prevalence of some infectious diseases may be higher in some groups of UM. For example, the reported tuberculosis (TB) prevalence among immigrants in Malta was 390/100,000 compared to 2.1/100,000 in the Malta-born[17]. In Berlin, the tuberculosis rate per 100,000 individuals was 28.3 (95%CI: 24.0-32.6) in first generation migrants, 10.2 (95%CI: 6.1-16.6) in second generation migrants, and 4.6 (95%CI: 3.7-5.6) in native residents[18]. The exact prevalence of TB in UM is unknown as those are not screened. However, it was estimated that in countries of low or intermediate incidence, UM represented 5-10% of TB cases[19]. The HIV prevalence among migrants is higher than in the general population[12]. Migrants arriving from North Africa (NA) and sub-Saharan Africa (SSA) carry higher rates of hepatitis C and B than the local EU population[20]. Incidence data in UM are lacking for Belgium. There is limited evidence about transmission of infectious diseases between migrant and native-born citizens[21].

1.3.3 Costs

Although it is commonly assumed that restricting entitlement of UM to health care result in a judicious utilization of public money, evidence is emerging that the opposite mechanism is more likely. In Germany, a study comparing the health expenditures between migrants with restricted access to health care and those with regular access over two decades reported that the cost of exclusion from health care and other welfare services was ultimately higher[10]. Interestingly, the researchers demonstrated that a restrictive amendment in 1997, which increased the waiting time to regular access from 12 to 36 months, significantly increased the level of expenditure differences between the groups[j]. Another research developed an economic model to calculate health care costs for hypertension and prenatal care in Germany, Greece and Sweden [22]. It showed that providing regular preventive care, as opposed to providing only emergency care, is cost-saving for healthcare systems. Treating a condition only when it becomes an emergency not only endangers the health of a patient, but also results in a greater economic burden to healthcare systems[22].

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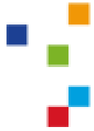
such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want; 4 to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

j However, another restrictive measure in 2007 did not result in such expenditure difference



1.4 Challenges

The right to health care for all might be implemented with difficulties for this particularly vulnerable population[23, 24]. It has been reported that UM have more difficult access to health care than other citizens and their health status is often also less optimal[25, 26]. Three broad sets of challenges have been identified in getting medical care[1]: lack of legal entitlements; language and cultural barriers; and implementation and access to services in practice. The first challenge is not prominent in Belgium as the access of UM to health care is guaranteed by law. The second challenge is real and has already been pointed out by a number of Belgian and European projects[25-30]. It relates to factors inherent to the migrant status such as difficult intercultural and interlanguage communication, poor knowledge of the health system, and precarious past and current living conditions. In contrast, the third set of challenges, the practical implementation of UMA, has not yet been systematically and objectively looked at in Belgium. The existence of complex, parallel, time- and money-consuming administrative procedures for these populations who are not part of the Belgian system of compulsory national health insurance is increasingly pointed out by diverse stakeholders as a crucial bottleneck in equitable access to health care[31]. The administrative procedures to grant access to health care for UM have been considered by some authors to be amongst the most complex ones in Europe[28].

In spite of the current political mobilization in Belgium about improving the indiscriminate access of every individual to health care and previous publications surrounding this topic[31], an in-depth and objective analysis of the UMA implementation in our country is lacking. In the absence of such analysis, it is impossible to identify strengths and weaknesses of the current policy and to propose adaptations to it, if appropriate.

2 OBJECTIVES

This report aims at providing an in-depth analysis of the current practice of Urgent Medical Aid for Undocumented Migrants in Belgium. It also aims at proposing, if appropriate, scenarios to improve the equilibrium between ensuring access to health care of that vulnerable population and the rational use of public resources. Legal and administrative procedures to access legal entitlements for residence are out of the scope of this report.

3 METHODS

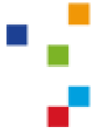
This project applies a mixed-method analysis approach. The main steps of the research and data sources are summarized in Table 1.

Table 1 – Main research steps and data sources

Steps	Data sources
1. Situation analysis (numbers, rules, costs, organization)	a. Semi-directive interview of 10 managers of the Public Social Welfare Centres (CPAS – OCMW) with the highest numbers of UMA. b. Review of the grey literature on UMA in Belgium, particularly legal documents c. Analysis of routine data collected by CPAS – OCMW on numbers of UMA applications and acceptation rates d. Analysis of routine data collected by the Federal Public Service for Social Integration (SPP IS-POD MS)[k], and by the Auxiliary Sickness & Invalidity Insurance Fund (CAAMI-HZIV)[l]
2. SWOT analysis	a. Interviews with 33 undocumented migrants (see section 5.2.2) b. Focus groups with 66 health care professionals and hospital managers (see section 1.1.1) c. Brainstorming sessions with key informants from governmental and non-governmental organisations with expertise in the field of health care for UM.
3. Elaboration of an alternative organizational model of UMA	a. Review of the scientific and grey literature on the access of UM to health care in a sample of European countries to draw potential lessons for Belgium (see section 6.1) b. Elaboration of a new organizational model accounting for the situation and the SWOT analysis. c. Consultation of stakeholders and key decision-makers consultation on the UMA reform
4. Scientific validation	a. Review of this report by 3 independent scientific experts (see colophon).

[k] This public organism bears the final responsibility of reimbursing health care delivered under UMA.

[l] This sickness fund manages claim data for UMA health care delivered in hospital since mid-2014



4 SITUATION ANALYSIS

4.1 Methods

4.1.1 Interviews

We contacted the 10 CPAS – OCMW delivering yearly the highest number of UMA agreement. All but one responded positively to our invitation. We also contacted afterward 2 additional CPAS – OCMW which piloted the implementation of MediPrima (see below). Therefore, in total 11 CPAS – OCMW were included in our study. The interviews with CPAS – OCMW staff (director of social action, social assistant, accountant) were semi-directive and followed an interview guide which is presented in appendix. The questions related to: current organization and procedures of AMU; difficulties met and vision for the future; number of annual UMA applications and the acceptance rate; human and financial resources devoted to UMA. The interviews took place in the CPAS – OCMW and lasted on average 1.5 hour. Interviews were not recorded but carried out by two interviewers who compared their field notes afterwards. Data of the interviews were extracted in a comparative table to highlight similarities and differences across CPAS – OCMW. Interviewees were re-contacted for complementary information when needed.

4.1.2 Routine data analysis

Data were extracted from two administrative databases owned by the SPP IS – POD MI to quantify the use of UMA.

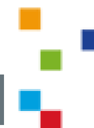
First, we received the aggregated expenses from the SPP IS paid to the CPAS – OCMW between 2006 and 2013 and the aggregated numbers of related unique beneficiaries. Expenses and numbers were broken into five categories: (1) hospitalisations (total costs including medical fees-for-service, drugs, hospital lump-sums, both for one-day hospitalisations and hospital stays lasting more than one night), (2) drugs from community pharmacies, (3) drugs from hospital pharmacies delivered in ambulatory setting, (4) medical costs (medical fees-for-service) of community caregivers and (5) medical costs of ambulatory care received at hospital. Supplementary aggregates of the total expenses were obtained by CPAS – OCMW, age and gender.

Second, an aggregated extraction was made by the SPP IS – POD MI from the Mediprima database, fed during the transition phase by the hospitalisation claims for the patients benefiting from a UMA granted by the four pilots CPAS – OCMW (Brussels-city, Antwerp, Charleroi and Kortrijk). Medical fee-for-service or lump-sum INAMI – RIZIV codes and drug reimbursement category codes as well as medical card periods of the treated UMs were transmitted with the exclusion of amounts paid and UMs identification. The data spanned from 9th July 2013 to 31st December 2014, according to the entry of each CPAS – OCMW into the phase.

We also calculated some 2012 figures from two other administrative databases pertaining to the national health insurance beneficiaries: first, the Permanent sample (EPS) which is a representative sample of the national health insurance beneficiaries and all their claims received by the sickness funds (hospital and ambulatory settings). This database is managed by the IMA. Second, we use the TCT database available at KCE, consisting of the medical discharge data (MZG – RHM) coupled to the hospital billing data from the sickness funds and managed by the Technical Cell.

The indirect standardisation method was applied to calculate a standardized average cost per UM, applying the national health insurance average cost 2012 per age and gender (drawn from the INAMI – RIZIV 2013 yearly report) to the 2012 UMA structure population transmitted by the SPP IS. A similar method was also applied to calculate the standardized rate of hospitalized patients among the UMA population, applying the rate of hospitalisation of the national health insurance beneficiaries per age and gender (drawn from the EPS 2012) to the UMA structure population. The 12 age categories used were: 0-19 years, brackets of 5 years and a bracket aged 70 or more.

Data transformation and analysis were performed using SAS 9.4 and Excel 2013.



4.2 How does UMA work?

Currently, the Public Centre for Social Welfare (CPAS – OCMW) acts as an intermediary institution between the UM and the health care system. Its mission is two-fold. First, it checks if the conditions to be granted UMA are fulfilled. Second, it defines on an individual basis the extent of the entitlements to health care. In principle, the UM must first go to the CPAS – OCMW to get the UMA agreement before accessing health care (Figure 1).

4.2.1 What are the conditions for UMA agreement?

The CPAS – OCMW will deliver an UMA agreement, i.e. it will cover the costs incurred by receiving health care only if a number of conditions are fulfilled[32, 33, 34].

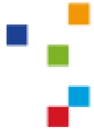
4.2.1.1 Territoriality: is the applicant living in the catchment area of the CPAS – OCMW (municipality)?

The CPAS – OCMW is competent to examine the UMA application if the UM has his/her effective residence on the territory of the municipality, i.e. if he/she lives there most of the time. If this is not the case (e.g. the UM lives on the territory of another municipality or the UM is already covered by another CPAS – OCMW), the CPAS – OCMW contacted will transfer the application to the competent CPAS – OCMW within 5 days. It may also happen that the UM receives health care before the approval by the CPAS – OCMW, notably for health care delivered in the emergency department of an hospital. In such case, the hospital will contact the CPAS – OCMW of the municipality where the UM lives most of the time. If the territorial competency of that CPAS – OCMW is not established for that specific demand, the CPAS – OCMW of the municipality where the hospital is located will examine the demand. If the UM is homeless, other pieces of information can be collected such as the testimony of associations providing assistance, food or shelter. The CPAS – OCMW will create a temporary identification number in the national register of population, the so-called "NISS-bis" code.

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

- **No insurability**. The CPAS – OCMW will check if the UM has already a health care insurance. This could be the case if the UMA applicant has been affiliated to a mutual health insurance fund previously (e.g. as a student or because having a work permit) and the affiliation is still valid. This is investigated by screening the Crossroads Bank for Social Security (BCSS – KSZ). The UM may also have a health insurance still valid in his/her country of origin. The CAAMI – HZIV will be contacted by the CPAS – OCMW to check this information. Lastly, the UM might have contracted a private insurance covering health care. Whether the UM comes from a country where a visa is compulsory to enter Belgium, whether he/she comes from a country with a liaison agency or whether he/she must be covered by the european insurance card, are additional information checks.
  If the UMA applicant resides in Belgium for more than one year, it is not necessary to check his/her insurability, but the applicant must provide documents proving the duration of his/her stay in Belgium.

  A last situation is when the UM has indeed an authorization to reside in the country, for instance because a procedure of asylum-seeking is still pending. In such case, health care can be covered by another organism and are not part of UMA.
- **No guarantor**. The CPAS – OCMW will send a request to the Office for Foreigners to check if a resident in Belgium has designed himself/herself as a guarantor of the UM. If this is the case, the CPAS – OCMW may ask the guarantor to ensure the payment of the health care needed by the UM.



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

The social enquiry will also include identification data of the UMA applicant, as well as the reason for residing in Belgium. If the applicant has no ID number in the national register (NISS), the CPAS – OCMW will deliver one, called the NISS-bis. During the social enquiry, a home visit is organized by a social assistant of the CPAS – OCMW for evaluating housing and living conditions, and confronting UM's declaration and reality[34]. After one year, the social enquiry must be redone, but it can also be updated in between when it appears that some of the information relating to the UM may have changed. The social inquiry is a legal obligation, the home visit is not[34, 35].

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

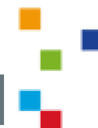


Figure 1 – Overview of Urgent Medical Aid

URGENT MEDICAL AID (AMU-DMH)
CURRENT FLOW FOR ONE DISEASE EPISODE

- UM: Undocumented Migrants
- CPAS-OCMW: Public Center for Social Welfare
- AMU-DMH: Urgent Medical Aid
- → : recommended path
- ··→ : alternative path
- → : blockage

Medical doctor certified that AMU-DMH is necessary

UM

Undocumented Migrant (UM)

CPAS-OCMW of the municipality assesses territoriality

CPAS-OCMW does social enquiry

Social enquiry on:
- Indigence
- Existence of other potential payers

CPAS-OCMW takes a decision of coverage (within 30 days)

Entitlement AMU-DMH (for 92 days)

Full access to care

Selective access to care

Selective access :
- Duration
- Type of Care
- Health care provider

Rejection AMU-DMH

No care

Care in NGOs

Care at Full cost

Care in Emergency Department Hospital

Percentage of UM in 2013
≈ 1.1%
of general population
(≈ 85 000 - 160 000)

Percentage of AMU-DMH in 2013
= 10%-20% of UM
(≈ 17 000)

0.2%

Cost of AMU-DMH in 2013
≈ 0.2%
of ZIV-AMI cost
(≈ 44 690 000 €)

2 to 26%

Rejection rate of AMU-DMH applications varies by CPAS-OCMW from 2% to 26%

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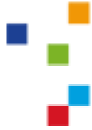

4.2.1.3 Is there an UMA certificate?

The need for UMA must be certified by a health practitioner, either a general practitioner or a hospital doctor if the first contact is at the hospital level, or a dentist. An UMA certificate is needed to get the UMA agreement even if no health care is needed in the short term, i.e. if the CPAS – OCMW wishes to anticipate future health care needs and complete the administrative tasks in advance. In principle, the UM must first introduce a request for UMA to the CPAS – OCMW before consulting a health practitioner and getting the UMA certificate. In reality, in some CPAS – OCMW a high proportion (>50%) of UM goes first to the medical doctor and submits thereafter the UMA certificate delivered by the medical doctor to the CPAS – OCMW at the same time as the application for UMA. This is particularly the case in situation of medical emergency. In principle, a UMA certificate is necessary for every new disease episode or treatment.

4.2.2 What decision can the CPAS – OCMW make?

4.2.2.1 Agreement or rejection?

Based on the results of the social inquiry, and if the other conditions are met, the social assistant in charge of the file will recommend to grant or refuse the UMA. This recommendation is first examined by a coordinator who may follow or not the recommendation made by the social assistant. For most cases, the decision power is delegated to the coordinator, and his/her decision will be automatically validated by the Council of Social Action of the CPAS – OCMW.

For more difficult cases, the Council of Social Action of the CPAS – OCMW[m] will examine the file and make the final decision. The CPAS – OCMW has 30 days after the introduction of the UMA request to decide if it will grant UMA or not.This decision is notified to the UM within 8 days by registered mail[n], with explanation for refusal, where necessary. In case of rejection, the UM may file a suit with the Labour court.

In case of agreement, the CPAS – OCMW provides the UM with a document called a “réquisitoire” which specifies health care and treatments covered and which is a guarantee of payment for the health care provider. However, an increasing number of CPAS – OCMW deliver an individual medical card instead of “réquisitoires”. The medical card specifies the general practitioner to be consulted and the pharmacy where to get the drugs can be obtained (sometimes the nurse or the physiotherapist if needed). With the medical card, the validity of which can extend to 1 year, the UM does not need to request an UMA agreement at the CPAS – OCMW for each disease episode or for every drug prescription by the GP (this may also apply for nurses or physiotherapists sometimes). For health care delivered at hospital, the notification of coverage by the CPAS – OCMW is done electronically since 2014, thanks to an computerized data transfer system called **MediPrima**. MediPrima connects the CPAS – OCMW, the hospitals and the CAAMI – HZIV, and the SPP IS-POD MS[36]. MediPrima will be extended to GPs and community pharmacies in a close future.

4.2.2.2 Defining the extent and the duration of the coverage

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

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

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[m] The Council of Social Action of the CPAS – OCMW consists of representatives of political parties

[n] Can also be given directly to the UM against an acknowledgement of receipt

4.3 How many individuals are concerned?

4.3.1 What are the global numbers?

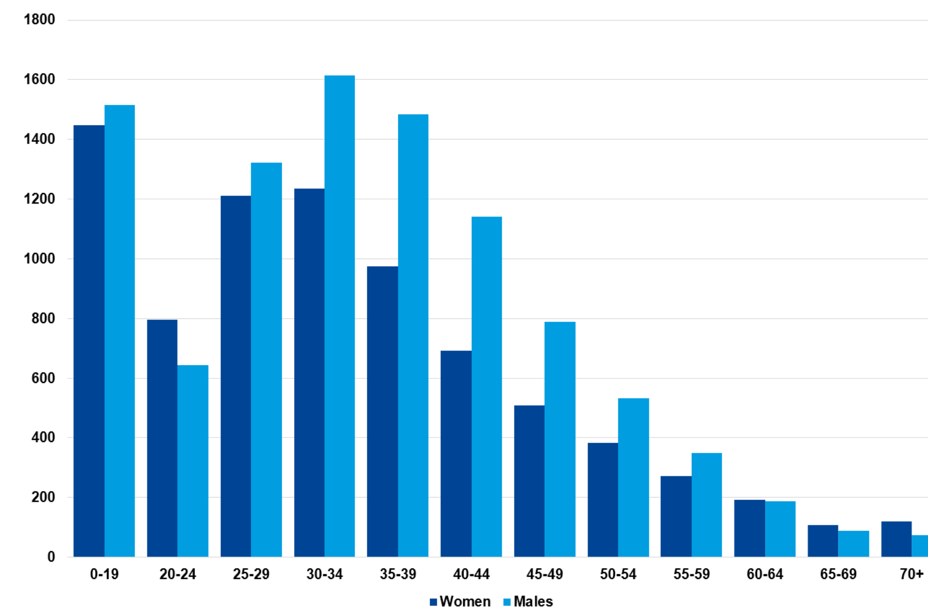
In 2013, 17 602 individuals benefited from UMA, 56.4% of whom were males. Figure 2 shows two frequency peaks, one in children <20 years and the other one between age 25 and 45 years, especially for males. The overall number has been quite stable since 2011, following a great decrease in previous years (Figure 3).

Indeed, the number of individuals who were granted UMA has decreased from 22 478 in 2006 to 17 602 in 2013. The origin of this decrease is likely multi-causal, one element being the regularization of a proportion of UM which occurred since 2008. The decrease was particularly marked in Brussels-city and Antwerp (Figure 4).

4.3.2 Is their geographical distribution?

The overall density of UMA beneficiaries is 163 per 100 000 inhabitants in 2013 (Figure 5). The geographical distribution of UMA beneficiaries is very uneven, with high concentration in cities, half of the beneficiaries being in the Brussels region (Figure 5). Within the Brussels region, UMA beneficiaries are mainly located in 8 of the 19 municipalities, and particularly in Brussels-city (Figure 4).

Figure 2 – Number of individual UMA by age and sex in year 2013



Source: POD MS – SPP IS

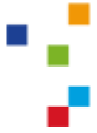


Figure 3 – Number of unique UMA beneficiaries over time (2006-2013)

24000
22000
20000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0

2006 2007 2008 2009 2010 2011 2012 2013

All
Hospitalized

Source: POD MS – SPP IS

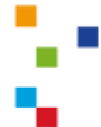


Figure 4 – Number of UMA beneficiaries per CPAS – OCMW (2006-2013)

8.000
7.000
6.000
5.000
4.000
3.000
2.000
1.000
0

BRUSSELS-CITY
MOLENBEEK-ST-JEAN
SCHAERBEEK
ANTWERPEN
LIEGE
ANDERLECHT
GENT
SAINT-GILLES
FOREST
IXELLES
ST-JOSSE-TEN-NOODE
SINT-NIKLAAS
CHARLEROI
KORTRIJK
MECHELEN

2006 2007 2008 2009 2010 2011 2012 2013

Source: POD MS – SPP IS

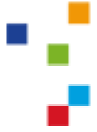
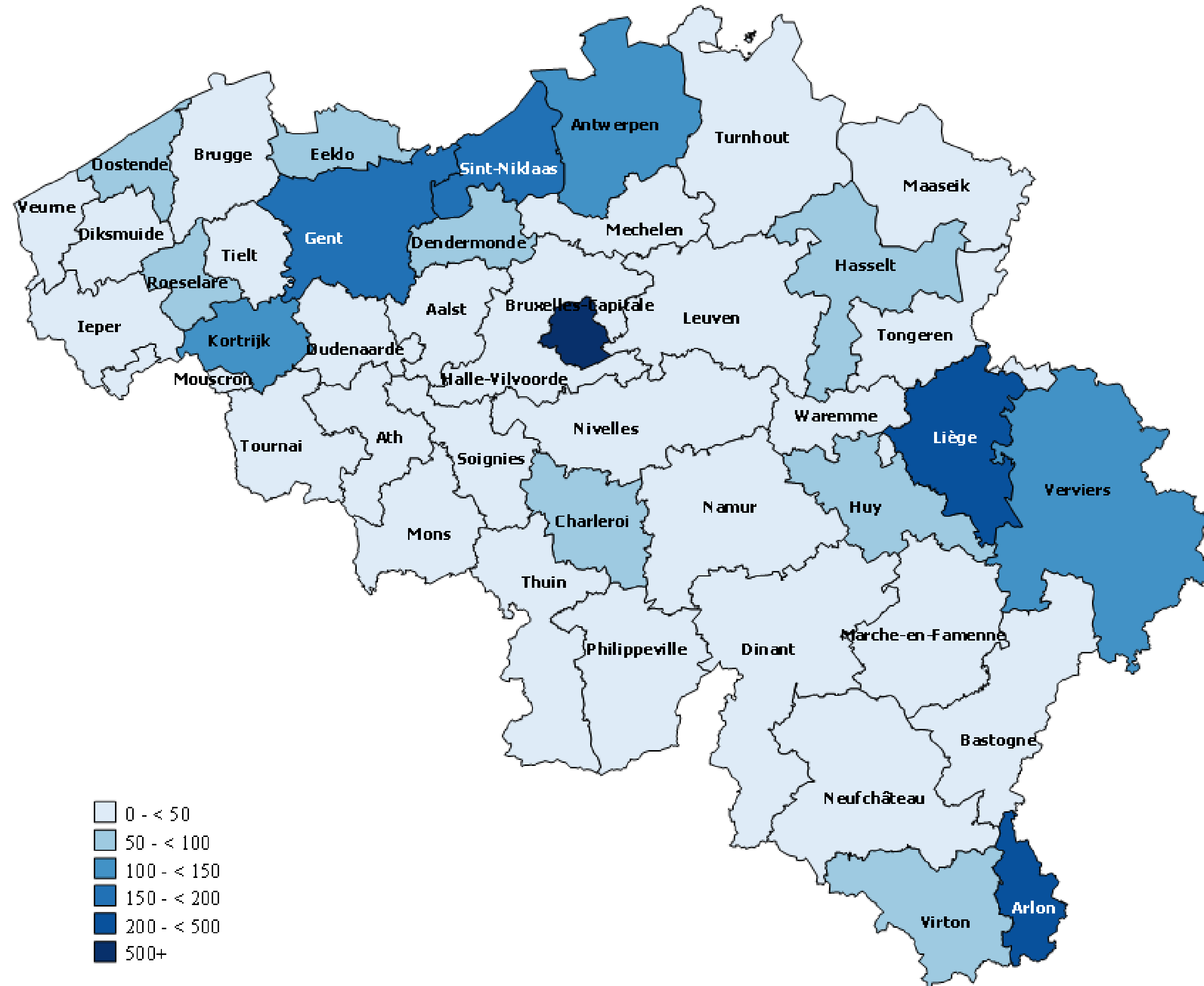
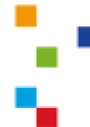


Figure 5 – Density of AMU beneficiaries in 2013



National Mean Rate = 162.7 per 100 000 inhabitants

Source: POD MS – SPP IS – KCE calculation



4.3.3 What is the health coverage?

We estimated that only between 10% (17 602/85 000) and 20% (17 602/160 000) of the UM population had at least one contact with the medical services during year 2013. As a comparison, this proportion approximates 90% for insurees with a Belgian mutual health insurance fund, independently of age and sex (source: EPS 2013).

4.4 What type of health problems?

The question has no straightforward answer as the routine databases usually at our disposal to identify the type of care delivered were not exploitable for UMA. 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. This database includes all claims data reimbursed under the national health coverage, in ambulatory as well as in hospital settings. Second, the hospital billing data transmitted by the sickness funds to the RIZIV – INAMI (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 undocumented migrants. Third, we explored the possibility of identifying hospitalized UM in the RHM – MZG. 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, that are presented in appendix, ensue from the recommendations made by the KCE[37] on the Impact of elective care for foreign patients on the Belgian healthcare system[o]. 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, undocumented migrants were registered in the 'not insured patients (including CPAS – OCMW)' before 2012 and 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 undocumented migrants in the MZG – RHM (other data fields such as country of origin and nationality are insufficient to identify UM).

Finally, we 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 UM. From 2012 onwards, the patient type variable disappears and the insurance institution takes the same values as the RHM – MZG insurability status.

Until 2014, all the billing was managed by the SPP IS – POD MI which has no expertise in dealing with medical data. This is still the case today for primary health care, whereas hospital data are managed by HZIV– CAAMI. However, these hospital data are not communicated to the RIZIV – INAMI. Therefore, the only data source at our disposal is the billing data of the POD MS – SPP IS.

Based on aggregated data that we received from the POD MS – SPP IS, the proportion of beneficiaries admitted in hospitals remains constant at around 20% (Figure 6), a similar figure as for the general population (19.6%, source=EPS 2012) but a lower figure than the 25% of insured persons entitled to a preferential reimbursement (so-called BIM for 'Bénéficiaires de l'intervention majorée')[p]. Considering the UMA population distribution in age and sex is different from that of the BIM population (younger, more males),

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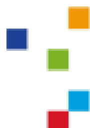
[o] https://kce.fgov.be/publication/report/elective-care-for-foreign-patients-impact-on-the-belgian-healthcare-system

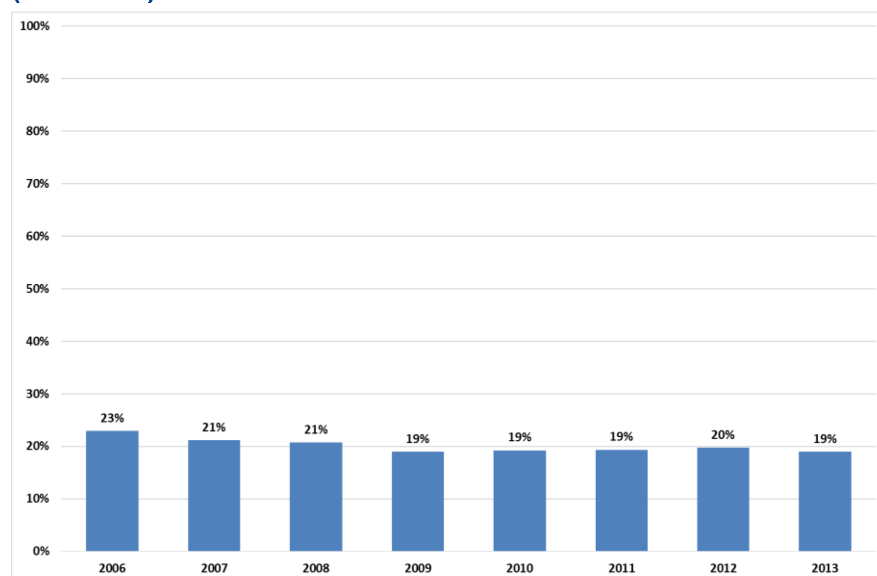
[p] We chose to compare the UMA population to the BIM population, considering the RIZIV – INAMI nomenclature tariffs for medical fees and drugs applicable for a UMA beneficiary are those applicable for a BIM insured person.



we calculated that the standardized proportion of AMU would amount to 21%.

Unfortunately it is currently impossible to analyze with precision health problems of UM. On the one hand, there is no functional registration of diagnosis, as explained above, on the other we have at our disposal only claim data from hospital. Whatsoever, analyzing morbidity profiles of UM was beyond the scope of this project.

Figure 6 – Proportion of AMU beneficiaries who were hospitalized (2006-2013)



Source: POD MS – SPP IS

4.5 How much does it cost?

4.5.1 Who is the payer?

4.5.1.1 Health care delivered outside the hospital

The CPAS – OCMW covers the costs incurred in the frame of UMA and gets reimbursed by the SPP IS – POD MI. The SPP IS – POD MI covers only care reimbursable in the INAMI – RIZIV nomenclature. If the CPAS – OCMW decides to cover health care usually not reimbursed within the INAMI – RIZIV 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.

The CPAS – OCMW must notify the UMA agreement to the MSI within 45 days following the first day health care was provided. Health care provided more than 45 days before the decision by the CPAS – OCMW will not be reimbursed to the CPAS – OCMW.

4.5.1.2 Health care delivered in hospital

Since 2014, a computerized system, called MediPrima, has been installed to connect CPAS – OCMW, hospitals, and CAAMI-HIZV to enhance information flows [q36].

The UMA decision by 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 UM receives an identification card with his/her name, picture and a NISS-bis number to be presented at the hospital. The health provider notifies through MediPrima that he/she has delivered care under UMA. The UMA certificate remains with the health care provider.

[q] The SPP IS – POD MI 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, 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 can control invoices following the same rules as for the AMI
4. To accelerate reimbursements to health care providers
5. To reduce barriers to health care services for UM.

Within MediPrima[r] invoices covered by an UMA will be paid directly by the HZIV-CAAMI[s] to the health care providers, reducing considerably the delays for reimbursement. The HZIV-CAAMI provides a monthly feed-back to PPS IS Social Integration and gets reimbursed. The system will be extended to GPs and community pharmacies in a close future. It could also include asylum-seekers.

A CPAS – OCMW can make 'a decision in principle' regarding a demand, i.e. it can notify in MediPrima that it is competent and that the UM is needy. This 'decision in principle' does not specify which health care will be covered by the CPAS – OCMW and is not equivalent to a guarantee of coverage. The main objective of this 'decision of principle' is to identify the CPAS – OCMW which makes the decision, thus blocking the possibility of any other decision by another CPAS – OCMW, and to 'help' CPAS – OCMW to respect the legal delay of maximum 45 days to make a decision regarding a demand (p21 of the MediPrima guide [36]). An UMA certificate is no longer needed for this 'decision in principle'. When the UM needs health care and the CPAS – OCMW decides to cover the costs relating to the health episode, a 'guarantee of coverage' by the CPAS – OCMW is notified in MediPrima. The CPAS – OCMW can also deliver *ex ante* a guarantee of coverage to the UM, which is valid for 3 months.

4.5.2 What is the annual budget?

The annual global budget paid by the SPP IS – POD IS evolved from 38 098 081 € in 2006 to 44 688 492 € in 2013, or 17.3% increase in 7 years (source: SPP IS – POD MI). As it can be seen in Figure 7, the relative proportion of the various budget compartments remained constant, with around 70% of the expenses dedicated to hospitalization (including drugs reimbursements and honoraria fees for hospitalized patients)[t]. UMA costs are increasing with age, as it can also be observed in the general Belgian population (Figure 8). The mean cost per beneficiary increased from 1 695 € in 2006 to 2 539 € in 2013 (+49.8% in 8 years) (Figure 9). This increase was mainly due to a more progressive mean cost increase of hospitalization (+76.3%). In absolute terms, the hospitalization costs increased by 14.2% (from 27 291 575 € to 31 171 111 € while the numbers of hospitalized UMA beneficiaries decreased by 35.2% (from 5146 to 3334 patients). Such an increase for individual hospitalization costs is not observed for the population with a legal health insurance: the total hospitalization costs per capita for this population increased with an average annual rate of 4% between 2008 and 2012 (source: TCT data, the trend is similar for the hospitalized BIM population). This increase could be due to more severe morbidities (because the access to health care was less optimal and patients were treated at a later stage of pathologies or because the case mix has changed over time for another reason) or possible changes in hospital billing. Data are currently lacking to address such questions in a scientific way (see section 4.4 for details on lacking data sources).

r http://www.mi-is.be/be-fr/e-government-et-applications-web/mediprima

s http://www.caami-hziv.fgov.be/Model4-10-F.htm

t A same proportion is observed for AME in France http://www.senat.fr/commission/fin/pjlf2015/np/np25/np255.html

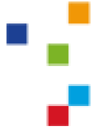


Figure 7 – UMA budget per year & per cost category (€)

Source: POD MS – SPP IS

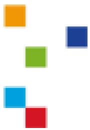


Figure 8 – Average UMA expenses per age and gender (€) (2012)

10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0

00-17 18-24 25-44 45-64 65-

Females Males

Source: POD MS – SPP IS

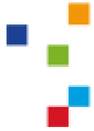


Figure 9 – Average annual expenses per UMA beneficiary and average annual hospitalisation expenses per hospitalized UMA beneficiary (€)

Source: POD MS – SPP IS

4.5.3 Are there geographical variations?

It is worth mentioning that the UMA expenses per individual are highly variable among CPAS – OCMW (Figure 10 presents average individual expenses from year 2006 to year 2013 over the 15 CPAS – OCMW with the biggest numbers of UMA beneficiaries). The factors associated with these variations are difficult to ascertain. They may reflect a different distribution of diseases in different populations. Municipalities where a referent hospital stands (e.g. In Brussels, St-Pierre hospital for tuberculosis and HIV/AIDS) may attract more complicated cases. These variations in per capita cost may also reflect various patterns of health care utilization, in relation either to different health care seeking behaviours or variations in the accessibility of health care services. Finally, in CPAS – OCMW with relatively small numbers of UMA, the average cost can increase tremendously by covering only few serious cases.

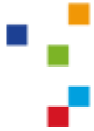
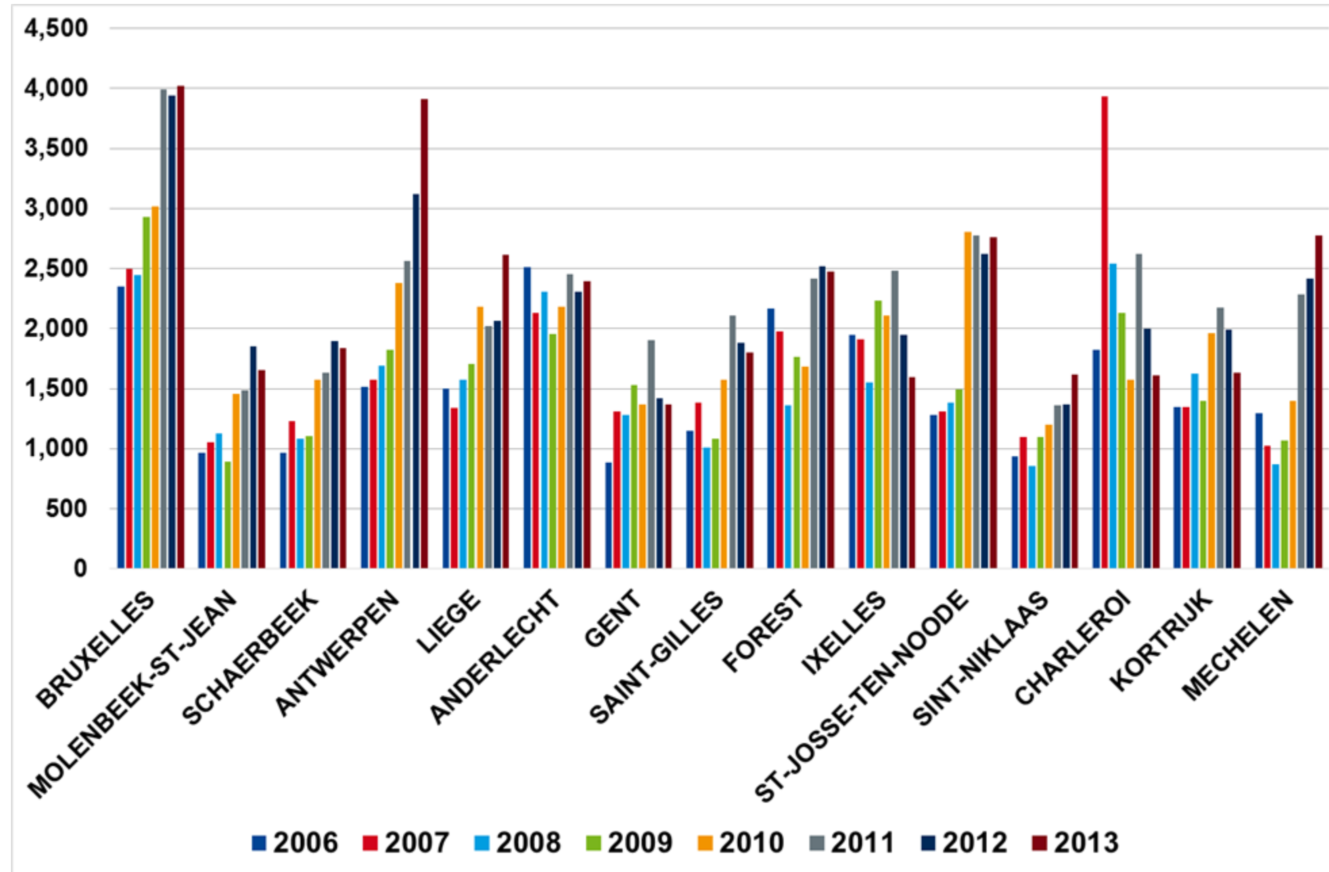
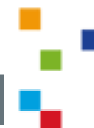


Figure 10 – Average UMA expenses per UMA beneficiary among the 15 CPAS – OCMW with the highest provision of UMA beneficiaries (€)



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



4.5.4 How does this compare to expenses by individuals in the INAMI – RIZIV?

To compare health care costs of individuals in AMU and in INAMI – RIZIV, a standardization of data is needed, i.e. the differences in age and sex distribution must be accounted. This was possible for data of year 2012. In 2012, the UMA expenses amounted to 42 573 035 € for 17 193 beneficiaries, i.e. 2 476 € per individual[u] (source: POD MS – SPP IS). When applying the average cost for health care of individuals with a legal insurance (INAMI – RIZIV), taking into account the age structure, the sex ratio and the insurance regimen (UMA beneficiaries are considered entitled to a preferential reimbursement) of the UMA beneficiaries (direct standardization), the individual cost would amount to 3 280 € (the average expenses for BIM patients in the INAMI/RIZIV being 4 925 €). In other terms, expenses for health care of UMA beneficiaries would be 24.5% lower than those of people covered by the national health insurance[v]. To investigate the origin of such difference on routine data is impossible. Various hypotheses may be put forward. The UM could be treated for different pathologies and/or in a different way than people within the national health insurance. This difference might also be to some extent an artefact. Indeed, the actual global cost of UMA is not known with accuracy because the above figures do not include the costs covered by the CPAS – OCMW on their own funds, and the costs incurred by hospitals (see section 4.6.3.3) and by NGOS which also delivered health care to UM. The statistics on the costs not covered by the SPP IS are not centralized.

4.5.5 Are there controls?

The CPAS – OCMW which has granted the UMA agreement bears the financial responsibility of it. The Minister of Social Integration makes regular a posteriori control visits and assesses on a sample of files if the procedures have been respected, i.e. if the substantiating documents have all been collected and are correct[32]. When this is not the case, the CPAS – OCMW will have to cover the corresponding costs, and potentially pay penalties (extrapolation of the results of the survey to all the files managed by the CPAS – OCMW), but there will be no penalty for the UM or the health care provider. During our field visits in CPAS – OCMW, it becomes clear that the financial responsibility of the CPAS – OCMW as regards UMA and the inspections by the SPP IS – POD MI create a climate of penalty aversion, i.e. the CPAS – OWCM feel under pressure to accumulate objective elements in support of each UMA application[w]. This is likely to result in extra burden for both CPAS – OCMW and UMA applicants, and possibly more refusals.

Within MediPrima, the HZIV-CAAMI is also responsible for the control of the invoices submitted by the health providers (electronic billing via MyCareNet if the error rate ≤ 5%). The HZIV-CAAMI also makes a random sampling of 5% of the files to check if the UMA certificate is available, and attempts to check in 1% of the files what health services were delivered in reality[x]. The HZIV-CAAMI also feed-backs the CPAS – OCMW about the individual expenses covered for UM in their municipality.

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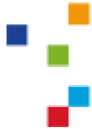
u The individual cost is remarkably similar to Aide Médicale d'état in France http://www.senat.fr/commission/fin/pjlf2015/np/np25/np255.html

v Such standardization focused specifically on hospital costs was not possible. The TCT data readily available at the KCE could not be used to compare the average hospitalization expenses of the undocumented migrants with the average hospitalization expenses of the population covered by the national health insurance, because the variable identifying the beneficiaries entitled to a preferential reimbursement was not transmitted to the KCE for privacy reasons.

w This is indeed recommended by the SPP IS – POD MI[32]

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



4.5.6 Is migration for health reasons documented?

When someone migrates with the objective of accessing health care in the host country, we talk of migration for health reasons. There is today no data to confirm or infirm that part of the UMA is delivered in that context.

Even for authorized medical migrations, data are difficult to ascertain, as reported in another KCE report[37], although this might improve with the establishment of the Observatory on Patient Mobility in 2011. The aforementioned KCE report showed that the relative number of hospitalizations remains modest, although on the rise[37]. The vast majority of such patients is from European countries (particularly from the Netherlands and France) with which trans-border conventions have been established. In countries where a visa to enter Belgium is compulsory, there were 1 918 visa applications for medical reasons in 2014[4]. The rejection rate was 19%, i.e. 1 554 individuals got an authorization. The bulk of applications was from African countries (n=1 072) and the refusal rate of those applications was 28%.

Data are more difficult to find to ascertain the proportion of individuals migrating to our country for medical reasons. An international survey carried out by Doctors of the World in 2014 in 7 European countries revealed that only 3% of the immigrants (65% of whom were undocumented) presenting at their medical consultation mentioned health problems as one reason for their immigration[38]. This proportion was similar in 2008, 2012 and 2013. Moreover, the median time between arrival in the host country and the first medical consultation in centres of Doctors of the World was 3 to 8 years. A major limitation of this study is the risk of selection bias, i.e. it is unknown if the respondents were representative of the whole UM population. Such data, although indirect and partial, do not point towards a massive medical tourism. We have not found neither obvious indications of medical tourism in our analysis of data from SPP IS – POD MS and CAAMI – HZIV[y]. Although the average individual costs for hospitalization has been rising quite sharply in recent years, and this might be due to more severe morbidity profile, it is today impossible to confirm or infirm if this phenomenon relates to health tourism (see section 4.5.2). The collection of routine data should be improved rapidly to get a more transparent picture of the care practice and costs of UMA. Such data collection is important to establish a fair and viable policy (see section 4.4 for lacking data sources).

4.6 What are the problems identified during the situation analysis?

4.6.1 Variations in social enquiry and rejection rate

Partly due to the lack of clear-cut legal description on the organizational aspects of UMA, and partly due to the autonomy of CPAS – OCMW to organize social support, the social enquiry can vary a lot among CPAS – OCMW, even within the CPAS – OCMW of the Brussels region.

1. We observed that the definition of indigence varies across CPAS – OCMW.

- In some places, the social assistant makes a recommendation to grant or to refuse UMA based on his/her global appraisal of poverty during the social enquiry, taking into account incomes and expenses of the UM. In other CPAS – OCMW, an income threshold is used beyond which the UM is considered not to be indigent. This threshold also varies from a CPAS – OCMW to another. In the CPAS – OCMW visited, it could be equivalent to the minimum welfare payment, or 110% of the minimum welfare payment topped with the equivalent amount of family allowances, or the minimum welfare payment + 250 euros.
- Sometimes, the costs of the health care needed by the UM can also be accounted for in the final decision to grant or refuse the UMA agreement. For example, the CPAS – OCMW may decide to not cover consultations in ambulatory care but to cover the costs incurred by a hospitalization.

[y] The SPP IS – POD IS provided us with the claim data of the first 1995 unique individual encoded in MediPrima. Although it was out of the scope of this project to perform thorough analysis of such data, we did not observe strikingly high statistics for specific care which could evoke medical tourism (e.g. plastic surgery n=4; vascular or cardiac surgery n=16; renal dialysis n=13). Between March 2014 and 19 November 2015, hospital claim data for 19 155 unique individuals were encoded in MediPrima.

- The extent of costs not covered by the CPAS – OCMW for UM not considered indigent can also vary dramatically. In some CPAS – OCMW, it is simply the co-payment of health care by the UM which is not covered by the CPAS – OCMW. In others, an all-or-nothing rule is applied, i.e. when the UM is beyond the threshold of indigence none of the costs will be covered by the CPAS – OCMW, at least in the ambulatory sector.
- There is quite room for interpretation of the situation by the social assistant, and little formal procedures for controlling if his/her recommendation to grant or refuse the UMA is adapted to a specific case.

2. We observed that the proportion of UMA demands refused is highly variable among CPAS – OCMW, going from 2.2% to 26%. Moreover, the reasons for refusal are not systematically recorded. The most often reported reasons for refusal were “lack of collaboration of the UM” or “impossible to prove indigence”. This entails refusal to comply with the home visit and/or the provision of documents to evaluate the indigence status. Reportedly, lack of indigence is rarely a reason put forward to refuse UMA. We observed that some CPAS – OCMW may justify their refusal by reasons not in line with the requisites of the social enquiry, e.g. an arrival in the country less than 3 months before the UMA application, lack of resources due to the migration, or health care available in the country of origin.

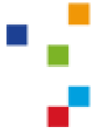
4.6.2 Variation in entitlement to health care

1. The entitlement to health care can be global (i.e. covering all the health care recommended by the health practitioner) or selective (i.e. the CPAS – OCMW has the power to decide what specific care or treatment will be covered). Such variations can be observed between CPAS – OCMW or among UM registered in a given CPAS – OCMW. The ground to make such decision is not straightforward. We observed that some CPAS – OCMW may ask to and/or obtain from the prescriber details on the medical file, breaching the medical secret. A minority of CPAS – OCMW hire a medical doctor to assess the legitimacy of the UMA certificate.
2. Health care expenses covered by the CPAS – OCMW outside the INAMI – RIZIV nomenclature vary from one municipality to the other, and within a municipality, from one UM to the other. Covering costs outside the INAMI – RIZIV nomenclature is decided, based on the analysis of the specific individual situation, by the Committee of Social Action of the CPAS – OCMW. In some cases, this entitlement can be automatic. For example, the 19 CPAS – OCMW of Brussels refer themselves to a common list of D drugs (e.g. pain killers) which they systematically cover.
3. The duration of the UMA agreement is most commonly 92 days. It can be shorter (30 days) or longer, as some CPAS – OCMW will prolong the UMA up to one year in case of chronic diseases.
4. Several interviewees emphasize that the concept of urgent medical aid is poorly defined by the law, generating misunderstanding and potential mistreatment of patients when the medical doctor on duty is unaware of the procedure or refuses to deliver health care when there is no true medical emergency. The law may be purposely vague in defining UMA to minimize cases of exclusion. However, the term of Urgent Medical Care let the door open for any interpretation by the local authorities to as how much the health care needed is urgent. For example, in one of the CPAS – OCMW a woman at 3 months of pregnancy was not considered eligible for UMA for her delivery.

4.6.3 How big is the administrative burden?

4.6.3.1 Social enquiry

1. The legal delay of 45 days imposed to CPAS – OCMW to notify the SPP IS – POD MI is considered short. First, getting the answer to the request sent to the CAAMI-HZIV about the existence of a health insurance in the country of origin, and from the Foreign Office for the identification of guarantors, usually takes time. In practice, this information is rarely available within the legal delay. Most CPAS – OCMW do not wait for these responses but add a copy of the requests to the file to make it obvious that the procedures were respected. Second, such legal delay forces the CPAS – OCMW to adapt the rule to avoid being penalized financially, e.g. to register the ‘decision in principle’ before the end of



the social enquiry to make sure that any health care provided more than 45 days before the decision of coverage will be reimbursed.

2. The social enquiry must be repeated at least once a year. However, in order to avoid being financially penalized in case of inappropriate UMA decisions, some CPAS – OCMW repeat the home visit every 92 days even if the UMA is granted for longer (e.g. in case of chronic disease), or at every new UMA demand for one given UM. Reassessment of the UM eligibility to get UMA can be done at any time when there is suspicion of a potential change in the UM situation. One of the CPAS – OCMW visited redoes the social inquiry monthly.

4.6.3.2 Territoriality

1. The condition of territoriality imposes that the social enquiry must be redone every time the UM enters a new municipal territory, i.e. the social enquiry done previously by another CPAS – OCMW is not valid. The condition of territoriality generates particular burden in the Brussels region where the territory of the 19 municipalities is closely interlinked and where the UM often cross from one municipality to the other following simple changes in housing arrangements. Defining geographical competency is even trickier around some magnet structures, such as railway stations (e.g. Brussels North station), standing on more than one municipality.

4.6.3.3 Health care preceding UMA agreement

1. A proportion of UM by-pass the administrative procedure and get health care at the hospital when necessary. This proportion is far from negligible. In the first semester of 2012, the CHU St-Pierre in Brussels reported that the vast majority of UM hospitalized (93.9%; 1 068/1 137) had no agreement from the CPAS – OCMW (“réquisitoire”). For ambulatory care, the proportion was 82.0% (4 376/5 334) (Personal communication: A. Cocle, responsible for social coordination IRIS network). In the CHU Charleroi during the first 10 months of 2015, 60% of patients whose health care were eventually covered by UMA had no agreement from the CPAS – OCMW at their admission.
2. When an UM directly gets health care at the emergency ward of a hospital, a social enquiry is started by the staff for social welfare of the hospital. However, the CPAS – OCMW will usually redo the social enquiry to avoid financial penalty in case of error. This is duplicated work. Moreover, it is not always possible to repeat the social enquiry, e.g. when the person is not retrieved or when she/he refuses the social enquiry.
3. When the CPAS – OCMW of the municipality where the UM has declared residing is unable to ascertain territoriality, the file will be transmitted to the CPAS – OCMW of the municipality where the hospital stands. This clearly increases the burden of CPAS – OCMW having a hospital on their territory. This is also the case for municipality having a magnet structure on their territory.
4. There is no guarantee that the CPAS – OCMW will cover the expenses eventually, as this decision will depend upon the social enquiry done by the CPAS – OCMW after the care has been delivered. As a result, the unpaid invoices can be quite substantial. For example, the invoices of the IRIS hospital network in Brussels not reimbursed by CPAS – OCMW amounted to 4 174 200 € in 2012 of which 80% is on the account of UMA (personal communication: A. Cocle, responsible for social coordination IRIS network). As an indication, the UMA paid by the POD MS – SPP IS – POD MI for the Brussels region during the same year was 28 530 340 €.

4.6.4 MediPrima

Although MediPrima simplifies financial flows, it also generates a number of difficulties:

1. A specific UM cannot be registered by two different CPAS – OCMW at the same time. As a result, a CPAS – OCMW cannot declare itself competent if another CPAS – OCMW has already done it. This generates a difficult situation if the UM does not live anymore in the municipality of the CPAS – OCMW which has declared itself competent in the first place.
2. During the (current) transition phase where MediPrima includes only health care delivered at the hospital, the CPAS – OCMW have to maintain two registration systems for each care line of the health system.
3. The personal identification of UM requires a photography. This procedure is deemed difficult by some CPAS – OCMW (and

inacceptable by one of the CPAS – OCMW visited) which consider that population filing is not their mandate. The impact of this new administrative constraint on health care utilization by UM needs to be evaluated.

4. The UMA lasts 3 months and is stopped automatically after that period. The possibility to authorize UMA for longer periods, especially in case of chronic disease, is not possible anymore.

4.6.5 Free choice of health practitioner

The free choice of the health care practitioner by the UM is sometimes limited. Most of the CPAS – OCMW develop working conventions with health practitioners, and the choice of the UM is limited to the list of practitioner with a convention.

4.6.6 Difficult communication

Interviewees report that rules may evolves rapidly and that it is sometimes difficult to know what is allowed and not, which together with the financial responsibility of CPAS – OCMW for UMA costs generates a climate of uncertainty and penalty aversion.

Moreover, the various circulars and technical documents of the SPP IS about UMA deserve to be clarified on a number of important operational points. For example, sentences such as “the more the proofs, the better the file”[32] or “It is up to the CPAS – OCMW to decide upon the most appropriate means to carry out the social enquiry” do not constitue clear indications of what information should be collected. Another example is the chapter around assessing the resources of the UMA applicant which does not mention what is exactly meant by resources (income, other resources,…), nor that resource assessment should also integrate an evaluation of expenditures (charges, debts,…)[33, 34].

4.6.7 Difficult monitoring of practices and costs

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

4.7 What are the good practices identified during the situation analysis?

The barriers/difficulties listed in section 4.6 are avoided or addressed in some CPAS – OCMW as the management autonomy of this institution allows adapting the procedures to a certain extent. Such good practice can be a crucial source of inspiration for other CPAS – OCMW (Table 2).

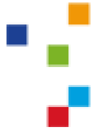


Table 2 – Good practices observed during the situation analysis

Good Practice	Difficulties addressed
1. Deliver a medical card for a few days so that the UM can access health care during the social enquiry 2. Prioritize social enquiry for persons with more urgent needs	Getting the UMA agreement can take up to 30 days
1. Deliver a medical card with entitlement for the GP and the pharmacist registered to deliver all services needed (only one UMA certificate) 2. Deliver such medical card even in the absence of health problems 3. Extend the medical card validity up to one year	Providing an UMA certificate for every health care service is cumbersome Renewing the medical card every 92 days is cumbersome
Detach a social assistant of the CPAS – OCMW at the hospital to perform final social enquiry during hospitalization	Duplicating the social enquiry already done at the hospital is cumbersome and often impossible leading to financial difficulties for the hospitals
The UM can choose any general practitioner provided that the latter accepts the convention with the CPAS – OCMW	The choice of health practitioner by the UM is often restricted to those ones having a convention with the CPAS – OCMW
Application of a consultation voucher at hospital admission: the quick assessment of the medical needs determines the urgency of care (type 1 emergency care needed, type 2 further examination and treatment needed but not urgent, type 3 consultation without necessary complementary examinations or treatments).	Next to the triage function of the standardized assessment, this document functions also as a financial guarantee for both the UM as the healthcare provider, i.e. the hospital finances this consultation and will meanwhile start up the UMA-procedure.
GP's office in the CPAS – OCMW: the UM can without delay consult a GP, who is familiar with the procedure applied by the CPAS – OCMW. Policy measures to facilitate medical care in specific subgroups (e.g. pregnant women, children)	Nevertheless the more restricted choice of the UM for a GP, the physical proximity between social and health services facilitates communication in between and promotes continuity of care. The application procedure for these groups will be shorter and the medical care will encompass a package of different care services.

4.8 Discussion

The CPAS – OCMW is a key-actor in the provision of social welfare. The current practice of UMA is extremely variable, resulting in various levels of administrative burden for all the parties implied (CPAS – OCMW, health care practitioner, UM) and various levels of access to health care for UM. Such variations contradict the principle of equity in health care embedded in the international treaties ratified by Belgium as the place of residence and the legal status of the applicant impact the access to health care. The discrimination in access to health care originates from variation either during the social enquiry or in the selection of health care to be covered. This is well illustrated by the extremely variable rejection rate from a CPAS – OCMW to the other, but the discrimination also occurs within a same CPAS – OCMW.

The main difficulties identified in our situation analysis take place at two levels. First, there is room for discrimination in granting (or rejecting) UMA. This is on the one hand the reflection of the management autonomy of CPAS – OCMW. On the other hand, this also reflects the pressure perceived by the CPAS – OCMW for playing the role of gate-keeper. Second, the entitlements to health care can differ. A better balance must be found between the management autonomy of CPAS – OCMW and the principle of equity in health care. To feed that reflection, the next chapter (section 5) investigates what the strengths, weaknesses, opportunities and threats of UMA are as perceived by both UM and health care providers.

5 SWOT ANALYSIS OF URGENT MEDICAL AID

This chapter was authored by Ines Keygnaert (ICRH-UGent), Marie Dauvrin (UCL), Birgit Kerstens (UGent), Julie Gysen (UCL), Vincent Lorant (UCL), and Ilse Derluyn (UGent)

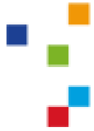
5.1 Introduction

This chapter aims at identifying strengths, weaknesses, opportunities and threats (SWOT) of the current procedures for granting undocumented migrants access to health care, with three sub-questions as per terms of reference:

- What are the difficulties for UM getting UMA approval (at the levels of health care providers and CPAS – OCMW)?
- Are there difficulties for UM getting access to health care under UMA?
- Does UMA generate major difficulties for health care services or administrative services?

The SWOT design of the research was part of the terms of reference, established by the KCE. As this research project aimed at supporting decision-making at political level, the SWOT analysis provides a unique venue to analyse systematically the organisations' contexts[39]. As identified by Shiffman & Smith, the environment surrounding the actors, the power of the actors, the portraying of the idea/the problem under consideration and the characteristics of the issues are the 4 main components to be taken into account in order to shape the political priority of an issue[40].

A stepwise approach, with a preparation phase, data collection and reporting phase, was applied. Data collection consisted mainly of a limited literature review, interviews with undocumented migrants and focus group discussions with health care professionals and managers. The whole process was guided by a group of key stakeholders.



This report reflects the methods and results as generated throughout the entire project: the literature review, the methodology of the interviews and the focus group discussions, the main results out of the SWOT analyses and some cross-cutting themes throughout all SWOTs. The three SWOTs are included in the appendices.

The study protocol was approved by the Ethical Committee of the Faculty of Psychology and Pedagogical Sciences at Ghent University (Nr 2015/21). Each participant of the study, including UM, was first informed of the project goals and participation means by phone and/or mail. Subsequently, they received an informed consent form, a short description of the project and contact data of the researchers in case of questions. Referral for further support of the UM was foreseen, if needed. All data were collected and analysed anonymously.

The study findings need to be interpreted within the framework of the study limitations. First, the study setting was limited to five large cities in Belgium, which means that generalising the findings to non-urban cities needs to be done with caution. Secondly, the number of interviewed undocumented migrants was limited, which could reduce the generalizability of the findings of this SWOT. Yet, saturation in this sample was reached. Moreover, although we do not have any specific indication that this might be the case, undocumented migrants might have felt reluctant to fully express their views, given their constrained living situation and 'undocumented' status. Thirdly, likewise in the group discussions, it could be that health care professionals or health care managers might have felt reluctant to openly talk about the strengths, weaknesses, opportunities and threats related to the procedure of urgent medical care. Fourthly, as the key informants had several roles in the process, a bias may have occur. However, we clearly separated the different roles in the way we approached the stakeholders.

5.2 Methodology

The methodology of this study consisted of three main parts: two brainstorming sessions with key informants, interviews with undocumented migrants, focus groups with health care professionals and managers and. This group of key informants also acted as the overall advisory board for the study. In this section, we describe the methodology used in this study, split up in the three study parts.

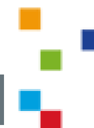
5.2.1 Advisory board of key informants

An advisory board of key informants was established with a twofold aim: first, we wanted to draft a first SWOT analysis on the procedure of urgent medical aid in Belgium based on the knowledge and expertise of these key informants; secondly, we wanted to ask for support and feedback on the two other study parts, the interviews and the focus group discussions, from this advisory board of key informants. For both purposes, two brainstorming sessions were held with this advisory board, one at the beginning of the project and one at the end.

5.2.1.1 Participant group

In order to select key informants, each researcher identified experts in the field of UM and health, and also the KCE researchers suggested additional names. Besides, the experts already identified were also asked to provide names of relevant persons who could join the advisory board. All these identified experts were contacted to join the advisory board as key informants. Participants to the advisory board belonged both to governmental and non-governmental organisations that provide support to undocumented migrants in accessing social and health services or have large expertise in this theme (e.g., Medimmigrant, Agentschap Integratie & Inburgering[z], Fedasil, Federaal Migratiecentrum, Samenlevingsopbouw Brussel) and organisations providing health services themselves (e.g. Médecins du Monde, Kind & Gezin, Projet Lama, Concertation Bas Seuil - CBS) (see Acknowledgement section).

[z] Including representatives from (1) Oriëntatiepunt Gezondheidszorg and (2) Kruispunt Migratie-Integratie.



5.2.1.2 Procedure

On March 19 2015, we organised a first brainstorming session with the key informants. The purpose of this session was threefold: first, we wanted to inform them on the project goals and planning; second, we aimed to discuss a first draft of the key informants' SWOT analysis, and, thirdly, we wanted to validate the research tools and procedures for the interviews with UM and the focus groups with health care professionals. After having introduced the project and based on written inputs from the key informants, a first draft of the SWOT was presented to the group, followed by a one-hour discussion. The SWOT deals with the legal and political framework of urgent medical aid in Belgium, the procedures to be applied by different stakeholders (health care providers, CPAS – OCMW, supporting organisations and undocumented migrants themselves), and the 7B framework as explained in chapter 6.

The draft SWOT matrix was a consolidated effort from different organisations and their individual perception of the strengths, weaknesses, opportunities and threats of urgent medical aid for undocumented migrants in Belgium. Inputs were received from Medimmigrant, Agentschap Integratie & Inburgering, Médecins du Monde, Jes (i.e. the Memorandum prepared jointly with other organisations in Brussels[aa]), Concertation Bas Seuil - CBS, Rotes Kreuz, Federaal Migratiecentrum, PICUM, and Kind & Gezin[bb]). A final SWOT was prepared taking into account all comments received during and after the brainstorming session.

A second, final brainstorming session with this group of key informants was held on June 15 2015. During this section, we discussed the outcomes of the interviews and of the focus groups discussions, the SWOT analyses that were drafted out of these two study phases, and we asked for feedback on the problems identified and solutions proposed.

5.2.2 Interviews with undocumented migrants

5.2.2.1 Participant group

Although there is a lack of data concerning the distribution of UM in Belgium, UM are mainly located in urban areas.[41] Based on the national statistics of the Belgian Ministry of Economy, we identified 5 cities (Antwerp, Brussels, Charleroi, Ghent and Liège) where UM are more likely to be located.[42]

As UM are considered as a hard-to-reach population, we used a snowball sampling approach through different seeds:

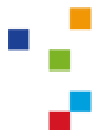
- NGOs (Médecins du Monde, Medimmigrant, Oriëntatiepunt Gezondheidszorg/Agentschap voor Integratie en Inburgering, SIREAS, Infirmiers de Rue, Samenlevingsopbouw, Pierre d'Angle, SAMU social, …) which participated in the first brainstorming session of the advisory board
- Health services which were identified to participate in the focus groups for health professionals
- Migrant networks of the researchers
- Respondents themselves.

We aimed at having a heterogeneous sample, including different profiles of undocumented migrants to gather as many different experiences and views as possible. Following inclusion criteria were used to select participants:

- Being undocumented in Belgium or have been undocumented until 6 months prior to the interview
- Living in (the region of) Ghent, Antwerp, Brussels, Charleroi or Liège
- Variety in following socio-demographic characteristics:
  - Gender: female, male
  - Within the female population: being pregnant/childbearing with babies/toddlers, or not

[aa] Samenlevingsopbouw Brussel, Dokters van de Wereld, Pigment, Medimmigrant, JES Brussel. Memorandum - Dringende Medische Hulp voor mensen zonder wettig verblijf - Waar knelt het schoentje? Juni 2012.

[bb] The Department of CPAS – OCMW of the Flemish and Walloon associations of cities and municipalities (VVSG and UVCW) –informed KCE that they do not want to participate in the SWOT analysis.



- Age: young adults (18-25 years old), adults (26-55 years old), elderly (more than 56 years old)
- Still having UMA at the moment or had UMA in the past[cc]
- Being in Belgium since less than 2 years, since 2 to 5 years or more than 5 years
- Geographical diversity: country of origin in Eastern Europe or Common Independent States (CIS) , North Africa and Middle East, sub-Saharan Africa, Asia, or Latin America
- Having a chronic pathology since more than 3 months or not
- Having recurrent or persisting mental health problems since more than 6 months or not
- Speaking sufficient Dutch/French/English/Spanish/German/Italian (European languages to which health care and social workers might be familiar) or speaking non-European languages solely.

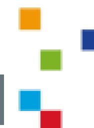
Thirty-three UM were interviewed in three Belgian regions: 12 in Flanders (Ghent: n=6, Antwerp: n=6), 11 in Wallonia (Liège: n=6, Charleroi: n=5), and 10 in Brussels. At the time of the interviews, 32 persons were still undocumented migrants and one person had a subsidiary protection, the “orange card” (socio-demographic profile of the participants: see Table 3). Twenty-one UM declared having children. Among these 21 UM, 12 declared having their children in Belgium, leaving 9 UM with children outside Belgium. Among the 12 UM having their children in Belgium, 3 UM declared living with only some of them. Regarding occupational status in Belgium, eleven UM reported not being allowed to work in Belgium while 9 UM reported an activity as volunteer, e.g. at the children’s school. Four UM reported themselves as house-wives, taking care of their children or new-borns. Five UM were not able to work because of ill-health or physical disability, such as impaired vision. Five UM had no employment at all, although some reported looking for a job but not finding any because of the absence of papers. One house-wife reported also an activity as volunteer.

Table 3 – Socio-demographic profile of the interviewees (n=33)

Socio-demographic characteristics	Number (n)
Gender	
• Women	17
• Men	16
Age (n=32)	
• Young adults (18-25 years)	1
• Adults (26-55 years)	28
• Elderly (56 and more)	3
Status before being undocumented	
• Has always been undocumented	10
• Subsidiary protection	9
• Denied asylum application	7
• Tourism visa	4
• Unknown	2
Length of stay in Belgium	
• More than 5 years	19
• Between 2 and 5 years	9
• Less than 2 years	4
• Unknown	1
Region of origin	
• sub-Saharan Africa	13
• North Africa & Middle East	12
• Eastern Europe & CIS Region	6
• Asia	1
• Latin America	1
Family situation (n=32)	
• In a relationship with children	13
• Single	10
• Single with children	6
• In a relationship without children	3
Family/partner in Belgium[dd] (n=32)	

[cc] If the UM did not experience herself/ himself a refusal of UMA, the interview asked about acquaintances of the interviewees who were denied UMA.

[dd] Family/partner refers to both children and other relatives. Family situation refers only to children or a partner.



Socio-demographic characteristics	Number (n)
• No member of the family lives in Belgium	17
• Yes, all the members of the family lives in Belgium	12
• Some members of the families live in Belgium	3
Living together with relatives (n=32)	
• No member of the family lives with the UM	20
• Yes, all the members of the family lives with the UM	9
• Some members of the families live with the UM	3
Children	
• Yes	21
• No	11
Living situation of children (n=21)	
• Live with parents	14
• Some children live with parents	4
• Do not live with parents	3
Mean number of children per family	3
Housing situation in Belgium	
• I live with my family	12
• I live alone	6
• I live with more than 5 persons (persons I did not know before)	5
• I live together with friends	4
• I live with more than 15 persons (persons I did not know before)	3
• Unknown	2
• Other housing situation	1
Housing type in Belgium (n=32)	
• Apartment/studio/house	21
• Precarious housing	4
• No fixed domicile address/homeless	3

Socio-demographic characteristics	Number (n)
• Reception structure for asylum applicants	3
• Therapeutic or medical institution with 24/24 care	1
Occupation status in the country of origin (n=31)	
• Employees	12
• Self-employed[ee]	9
• Labourers or workers[ff]	4
• Students	3
▪ House-wife or house-man	3
▪ Army	1
Perceived health status[gg]	
▪ Very bad	7
▪ Bad	9
▪ Neither good nor bad	10
▪ Good[hh]	6
▪ Very good	2

5.2.2.2 Procedure

The interview guide, available in English, French and Dutch and in its first version based on the literature review and on input of the key informants, was pilot tested with two respondents, upon which we slightly modified it (see appendix for the final English version). The interview guide included open questions around five main topics: socio-demographic data, general health situation, experiences with urgent medical aid, accessibility of the procedure of urgent medical aid, and solutions to improve the urgent medical aid procedure.

The interviews were conducted over a period of two months (April-May 2015). Interviews were mainly in French (n=21), English (n=7) and Dutch (n=2). Three interviews were conducted in the mother tongue of the undocumented migrants with support of interpreters (Arabic, Armenian and Russian).

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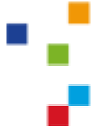
ee Including 1 UM reporting herself as a contributing spouse

ff Including 1 UM working in a cooperative

gg Scale retrieved from the National Health Interview Survey, see [43]

hh Some participants declared they have a very good health status, but that their relatives have a very bad health status.



Participants were firstly contacted by the intermediary NGOs, key migrants or health services to ask if they agreed to participate and if their contact information could be given to the researchers. Researchers then contacted possible interviewees personally, by phone or email. Appointments with UM were then organised, either by the intermediary or by the researchers; the location of the interview was chosen by the participant. Most interviews were conducted in a meeting room of the intermediary organisations (n=25); six interviews were held at UM's place, and two interviews at the researcher's place.

The study aim and procedure were explained to the participants before the start of the interview; anonymity and confidentiality of the information given was stressed, as also that the interview would in no way impact any ongoing procedure or care. Recording by dictation machine, under guarantee of anonymity, was approved by all the interviewees, except three. In those 3 cases, interviews were handwritten. Interviewees received a list of supporting organisations as well as the researcher's contact details for further information or support, if needed, after the interview. All interviewees gave their written informed consent (see appendix). During the interview, active listening and reformulation were used to test speech understanding and to avoid misinterpretation as much as possible. Interviews lasted 45 minutes to 2h30 (in case of interviews with families).

At the end of the interviews, the UM participants received a financial compensation for their time and participation by means of a supermarket voucher of 15€. Participants were not informed about this incentive at the beginning of the interview.

5.2.2.3 Data analysis

First, all interviews were transcribed by the researchers. Using a Thematic Analysis approach, emerging themes were identified in three interviews. Based on these emerging themes, a first coding arborescence was developed, including sociodemographic data. Hereby, the researchers met regularly to discuss the coding book and the final themes before coding all a part of the interviews. To this raw data tree, we applied the 7B framework as first coding analysis scheme. Table 4 presents the different categories of the 7B framework. In this study, reachability is defined as the (lack of) thresholds when care is needed, e.g. absence of a gatekeeping system while affordability is defined as "financial and other costs that patient may encounter" in health care services. Gradually, codes were added until saturation. Subsequently, all codes were inserted in an Excel database. Out of these data, a SWOT matrix was drafted, and approved by the key informants in the session of June 15, 2015. The same coding three was used for both interviews and focus groups.

Table 4 – The 7B framework on access to health care

Dimensions	Definition of the dimension	Examples of interventions
Reachability	(Lack of) thresholds when care is needed	Absence of gatekeeping system
Functionality	Extent to which the patient experiences the care as supportive	Single point of entry
Availability	Existence of a supply and of (social) services which can be called upon for matters that do not relate directly to the assessed problem	Existence of dental care service in first line of care
Knowledge	Extent to which the patient is aware of the existence of the services	Information is provided to the patients through other services (e.g. schools)
Affordability	Financial and other costs that patient may encounter	Fees for services are based on the income of the patient
Reliability	Extent to which the patient can trust the services and the professionals	No need to provide ID documents
Comprehensibility	Extent to which the patient is aware of the reason for the intervention and the way in which the problem should be approached	Provision of cultural mediators or social interpreters

Adapted from Roose & De Bie (2003)[44].

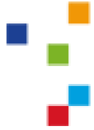
5.2.3 Focus groups with health care professionals and managers

5.2.3.1 Participant group

Six focus groups, all a mix of health care professionals and health care managers, were held in May 2015, in the same cities where interviews with UM were conducted. Following inclusion criteria were set:

1. for the health care professionals:

- majority of the participants need to have extensive experience in providing direct health care to UM (more than 5 years); besides we included some participants with up to 3 years' experience
- majority of the participants need to work in a health facility that is known to provide health care to a large amount of UM per year; besided we included participants working in rather small health facilities in areas with a dense migrant population
- the health facility in which the participants work is a hospital or primary care service (wijkgezondheidscentrum (community health centre), Groupe Local d'Evaluation Médicale (GLEM, local group of medical evaluation), maison médicale (integrated health service), small general practitioners' practice)
- the participant's health facility is located in and around the broad areas of Ghent, Antwerp, Brussels, Charleroi or Liège
- the professional is preferably working at one or more of the key services in providing health care to UM: for hospitals: emergencies, gynecology/obstetrics, maternity, pediatrics, geriatrics, urology, gastro-enterology, endocrinology, psychiatry, social service (at least 3 per FG); and for small health facilities/practices: general practitioners, social nurses, receptionist, physical therapist (at least 2 per FG).



2. for the health care managers:

- the participant needs to have extensive experience in managing a health facility known to provide health care to a large amount of UM per year (preferably more than 10 years)
- the health facility is a hospital or primary care service (wijkgezondheidscentrum (community health centre), Groupe Local d'Evaluation Médicale (GLEM, local group of medical evaluation), maison médicale (integrated health service), small general practitioners' practice)
- the health facility is located in and around the broad areas of Ghent, Antwerp, Brussels, Charleroi or Liège
- the manager is part of the general board, board of directors, general management of the facility, or management of a key service (cf. services as mentioned in health care professionals).

Through purposive sampling, possible participants for the focus groups were contacted directly (first through a phone call, followed by a written invitation by e-mail). If invited participants were unavailable or refused, and the maximum number of participants was not yet reached (set at maximum 15 per group), participants with a similar profile were invited in a second wave of invitations. We did not succeed in including pharmacists and solo general practitioners in our sample. Main reasons for non-participation were the workload and the low exposure to UM. The final sample was made up of 66 participants, representing the different professional profiles (health professionals (n=24), health care managers (n=19) or social assistants (n=23)), and the various types of services (primary care services (n=24), hospitals (n=29), specialised health services[ii] (n=12), social service (n=1).

5.2.3.2 Procedure

A guide for the focus group discussions, drafted in English, French and Dutch (see appendix for the final English version), was made based on literature, the interviews with the UM, and the input from the key informants. The guide included on the one hand a series of open key questions, and on the other hand nine clinical vignettes that we had drafted based on the interviews with undocumented migrants. Twelve questions divided over five levels/elements were asked when discussing each clinical vignette: (1) (inter)personal level of provider-patient, (2) organisational level at health facility, (3) exo/local political/legal level, and (4) societal level, and ending with (5) a question for all levels (solutions and future prospects). The clinical vignettes were validated by health care professionals and managers working at different health facilities in Ghent and Brussels who did not participate in the Focus Group discussions.

The six focus group discussions, each with about 10 to 15 participants, were conducted in May 2015. Two focus groups were held in Brussels (one in Dutch and one in French), one in Antwerp, one in Ghent, one in Charleroi, and one in Liège. The meetings took place at the KCE (the two FG in Brussels), in university meeting rooms (Charleroi, Ghent), in a meeting room of the Local Center of Health Promotion[jj] (Liège) and in a meeting room of Kind & Gezin (Antwerp) and lasted all about an hour and a half. The groups were moderated by one or two reserarchers, and an additional notetaker was present to take extra notes during the session.

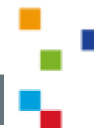
Before starting the discussion, we explained the aims of the study to the participants, stressed the anonimity and confidentialy of all data gathered, and provided the participants with our contact details, hereby offering the possibility to receive research results if wanted. Recording by dictaphone of the discussion, under guarantee of anonymity, was approved by all the participants, and all signed an informed consent (see appendix).

5.2.3.3 Data analysis

Focus group discussions were transcribed literally, including the notes taken during the session. Using the coding tree from the interviews, researchers coded the data from each focus group discussion independently. All encodings and quotes were synthesised in an Excel database. Out of these data, a SWOT matrix was drafted, and approved by the key informants in the final session on June 15, 2015.

[ii] Including health services for mother and newborns (such as Kind & Gezin, ONE) and mental health services.

[jj] CLPS de Liège : Centre Local de Promotion de la Santé.



5.3 Results: the SWOT matrices

Three separate SWOT analyses were prepared, based on the inputs from the key informants, the undocumented migrants, and the health care professionals and managers (HCP) (see appendix). In each SWOT analysis, we addressed the views of the 'designers' on the strengths, weaknesses, opportunities and threats of UMA for undocumented migrants. We have structured the SWOT matrices around two large themes, the legal and political framework and procedures, and the provision and quality of urgent medical aid for undocumented migrants. Each main theme has seven subthemes, with in the second main theme the 7B framework as overall framework:

A. the legal and political framework and procedures:

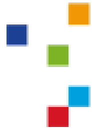
- (A1) the right and entitlement of undocumented migrants to be granted urgent medical aid
- (A2) the national legislation
- (A3) the national policy
- (A4) the procedures and their impact on UM
- (A5) the application of the procedures from the perspective of health care providers
- (A6) the practices of the CPAS – OCMW
- (A7) supporting NGO practices

B. the provision and quality of urgent medical aid for undocumented migrants:

- (B1) reachability
- (B2) functionality
- (B3) availability
- (B4) knowledge
- (B5) affordability
- (B6) reliability
- (B7) comprehensibility

In what follows, we discuss these different themes and topics, whereby we each time address the most important strengths, weaknesses, opportunities and threats that were mentioned in the different SWOTs. If a particular topic is not discussed in one or more SWOTs, we will explicitly mention this. For a detailed overview, we gladly direct the reader to read appendices 6 to 8 which contain the three SWOT matrices.

Yet, before proceeding to the findings out of the SWOT matrices, we want to address some elements related to the SWOT method and terminology: At first, for most participants, it was relatively easy to identify the 'Weaknesses' (so: the *problems*) in the procedure of Urgent Medical Aid. However, when looking at the responses related to 'Strengths', we see a more blurred picture, whereby, on the one hand, participants indicated elements in the procedure that are 'strong points', 'good' elements that can be taken as points to further build upon in the future – so the 'Strengths' as usually conceptualised in a SWOT analysis. On the other hand, this 'Strengths' part revealed many indications on how people try to deal with certain problems (weaknesses) in the procedure, as ways of '*coping'* and ways of '*going about'* certain challenges. As such, we cannot always consider these as real 'Strengths' as set in 'SWOT language'. The same holds for the 'Opportunities': little 'real' 'Opportunities', as conceptualised in a SWOT analysis, have been indicated, and most 'Opportunities' are rather '*solutions'* to existing barriers and problems in the procedure. Interestingly, the participants did not reveal many issues fitting under the section 'Threats'. Some points were clearly indicated, but at the same time, it was not always clear how to distinguish these 'Threats' from the 'Weaknesses' indicated. This could relate to the fact that some participants mentioned that they fear that future changes in the law and/or procedure might considerably lower the possibilities they have now, hereby decreasing the accessibility and broadness of the procedure that are now still there. Last, it needs to be stressed that some elements can both be viewed as a 'strength' and as a 'weakness'.



5.3.1 Legal and political framework and procedures

5.3.1.1 Right/entitlement of undocumented migrants to be granted urgent medical aid

Note: This topic was not brought forward in the SWOT of the undocumented migrants. HCP contributed to this topic only regarding the aspect “strength” but did not provide inputs for the Weaknesses/Opportunities/Threats.

Strengths

Key informants and HCP highlight the strength of urgent medical aid being a fundamental right which entitles undocumented migrants in Belgium to receive both preventive and curative care and treatment within the regular health care system, as stipulated in the Royal Decree of 12 December 1996. Compared to other European countries (e.g. Germany), the right to urgent medical aid has a strong legal basis in Belgium with few barriers to entry.

Weaknesses

Unfamiliarity of the right to UMA, due to lack of information among UM, but also among health care professionals (see also on knowledge of UMA), implies that not all undocumented migrants activate this right, even when being entitled to. Some individuals experience difficulties in activating the right or are excluded from urgent medical aid, such as homeless people who cannot demonstrate that they stay on the CPAS – OCMW territory where they seek help, or economically inactive European citizens.

Opportunities

The universality of the right to UMA gives undocumented migrants the indisputable possibility to claim their right to health care and to lead a dignified, safe and healthy life in Belgium.

Threats

The right of undocumented migrants to be granted urgent medical aid in Belgium may be susceptible to future restrictions as a result of the prevailing legislation in neighbouring countries with limited right to UMA. (Perceived or factual) abuse of the right to urgent medical aid by (some) individuals could also lower its public and political support in Belgium.

5.3.1.2 National legislation with respect to urgent medical aid

Note: This topic was not brought forward in the SWOT of the undocumented migrants

Strengths

When complying with the legal conditions (i.e. being undocumented, being deprived and showing the medical card), the right to UMA is enforceable, and entitles undocumented migrants to a broad package of preventive and curative care, as described in the Royal Decree of 12 December 1996. The fact that urgent medical aid is assured by a federal law certainly results in less regional differences. Moreover, the Social Welfare Act of 8 July 1976 applies to urgent medical aid as well and guarantees professional secrecy of social assistants and the right of UM to get a proof of receipt when submitting an application. Confidentiality of personal and medical data of UM is also guaranteed.

Weaknesses

Key informants allude to the existing confusion about the definition of urgent medical aid as an essential weakness. Especially the wording of urgent medical aid is problematic, since it induces a lot of misunderstandings by health professionals and social assistants for two of the three words, with 1) "urgent" being interpreted as in "emergency", and "medical" as in "strictly medical". While the Royal Decree of 12 December 1996 clearly refers to curative and preventive care, HCP confirm that the current legislation leaves (too) much interpretation by actors involved in granting access to UMA which in turn creates discretionary situations. Furthermore, the UMA legislation changes regularly and is "regionalised" at implementation level, thereby adding an additional level of variation to the Belgian model.

Opportunities

Because human rights in general and the rights of the child specifically are to be respected, the current Belgian legislation with respect to urgent medical aid could set an example for other European countries (such as Germany). HCP claim that a clear definition of urgent medical aid would result in less ambiguity and arbitrariness and suggest replacing the word "urgent" by "necessary" or "essential", and the word "medical" by "health", since this reflects better the type of care needed.

Threats

Key informants assume that a legal (re)definition of urgent medical aid possibly implies a reduction of the current health care package of UMA. HCP expect an equal reduction of UMA coverage in case of harmonisation of UMA procedures, especially in those cities where the scope is currently broader. “Regionalising" the UMA legislation probably implies large differences in interpretation and application and therefore unequal treatment of undocumented migrants.

5.3.1.3 National policy with respect to urgent medical aid

Note: This topic was not brought forward in the SWOT of the undocumented migrants

Strengths

The absence of a restricted envelope budget or a maximum ceiling for the government's spending on UMA is considered a positive aspect of the Belgian policy with regards to urgent medical aid and suggests that financial reasons cannot limit provision of care to undocumented migrants.

Weaknesses

Key informants see several weaknesses in the Belgian policy, amongst them the ambivalence in interpretation of the right to urgent medical aid at the operational level (i.e. by CPAS – OCMW), the lack of information being disseminated to health care providers, and the limited public support and acceptability of the (perceived high) cost of offering UMA to UM in times of financial crisis. HCP have mixed feelings about the recently introduced MediPrima system with the sceptics referring to the limited reachability of health care services to only the ones available in the region having an agreement with CPAS – OCMW.

Opportunities

Reappraisal of the role of CPAS – OCMW in granting urgent medical aid to undocumented migrants, complemented with adequate resources to implement the UMA policy, is considered an opportunity by key informants in order to improve the current policy and procedures and to correct the existing perception of discretionary interpretations and decisions. According to some key informants the establishment of a central control body could enable the activation of the right of UMA with one procedure which is to be applied as standard across the country, while others believe that the establishment of a regionalised institution of public utility that deals exclusively with UMA could simplify procedures for the actors involved. Focus groups participants suggest that standardising and simplifying the current procedures, with an electronic social patient file and a well-functioning MediPrima system, would leave no or less room for discretionary interpretations. Full coverage of care for undocumented migrants, including e.g. vaccination or treatment of tuberculosis, could have positive effects on public health.

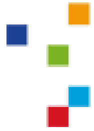
Threats

According to key informants, several contextual aspects threaten the current policy of urgent medical aid for undocumented migrants, such as more repression towards undocumented migrants, probable fixation of the government on 'fraudulent' UMA certificates, and diminishing public support for UMA among the Belgian population. The political and economic context and subsequent need for public spending cuts could be used by the Belgian government as an argument to reduce the coverage of UMA. HCP regret that even with the MediPrima system the CPAS – OCMW remain in charge of indicating the type of care needed, while this should be the responsibility of health care providers and jeopardises their medical role.

5.3.1.4 Procedures granting access to UMA: impact of client characteristics

Strengths

Despite the requirements to be fulfilled to get access to urgent medical aid, key informants appraise the current system for being ‘close to the people’ and for guaranteeing the privacy of undocumented migrants and confidentiality of information that they disclose (e.g. to social assistants at CPAS – OCMW). HCP mention the ‘creativity’ of health facilities to assure that the medical card is provided, e.g. by declaring that patient is homeless when not being able to give address. Undocumented migrants themselves appreciate that current procedures allow to activate the right to UMA before being ill, and that procedures have been simplified with introduction of the medical card.



Weaknesses

Procedures to obtain access to urgent medical aid are observed to be complex and cumbersome. Undocumented migrants themselves refer to the conditions imposed by the CPAS – OCMW, such as the need to give an address, to prove health needs, and to accept a social inquiry, including the visit of the CPAS – OCMW's social assistant at the given address. Key informants and HCP consider these administrative requirements as criteria of exclusion straining the provision of treatment and care to undocumented migrants. Additional requirements when seeking medical aid increase the complexity and burden of the procedures: the need for UM to go first to CPAS – OCMW before accessing health services, the need for UM to meet the health care provider first before initiating a treatment or before accessing specialty care, the need to go several times to CPAS – OCMW for a single procedure or to reactivate the right to UMA when undocumented migrant changes residence to another municipality.

Opportunities

Suggestions to simplify the UMA procedures include a declaration on honour of the undocumented migrant as proof of indigence (like in France), or just not requiring to provide an address so that UM do not fear repercussions which endanger their precarious stay and support from other people in precarious situations. Undocumented migrants themselves are grateful for the support received from NGOs to obtain UMA, and see opportunities in those organisations (continuing to) providing specific treatment and care.

Threats

None identified. If there would be no right to UMA, access to the health care system would be problematic for undocumented migrants because they would not be able to seek (medical) help and would have to rely on informal care, their network of family and friends and/or on self-medicine and self-medication.

5.3.1.5 Procedures granting access to UMA: perspectives of health care providers

Note: This topic was not brought forward in the SWOT of the undocumented migrants.

Strengths

From the perspective of the health care providers key informants highly value the clear delineation of responsibilities between CPAS – OCMW and doctors, with the latter deciding independently about activation of the right to UMA. HCP consider it a strength that health care providers and social services of health facilities initiate UMA procedures themselves, often even arranging language assistance and administrative work before the UM attends the health facility, and intervening or referring pro-actively (e.g. in case of newborn children, children, pregnant women). Some participants reveal that where performing well, MediPrima simplifies the current procedures for health facilities.

Weaknesses

Key informants see weaknesses in health care providers being unfamiliar with the procedures and concept of UMA and/or applying different practices, leading to discretionary situations, terminological discussions and even delay of timely care or treatment. HCP reveal that UMA procedures imply an extra burden for health care providers or facilities that initiate UMA, and that by doing this health care providers are transgressing their medical responsibilities and jeopardising their medical secrecy (i.e. by disclosing medical information about the patient). For solo GPs the UMA procedures are nearly infeasible to comprehend and arrange without administrative support while for community health centres and hospitals it requires enormous efforts from their social assistants. The complexity of the MediPrima system requires technical support.

Opportunities

Increased familiarity of health care providers with the procedures of UMA could result in a workable system. Key informants also stress that all health professionals should be allowed to activate the UMA right. HCP confirm that there would be no swapping of roles if all actors involved would stick to their responsibilities as defined by law. They suggest for example to protect (the medical role of) the doctors by introducing a consultation voucher at hospital level[kk]. When further adjustments are made to the MediPrima system, it could be a reliable, clear and understandable system for everyone (i.e. hospitals, community health centres, and individual doctors).

Threats

According to key informants the current UMA procedures potentially create accessibility barriers because in theory an assessment (e.g. social enquiry) is needed first, and health care is only given when the right to UMA is activated. The interpretation of 'urgent' could result in health care providers deciding discretionarily that care and treatment are not urgent. HCP perceive that professional (medical) secrecy might be at risk if health care providers need to contact and inform social assistants of CPAS – OCMW, and that even their sovereignty to define what is medically urgent or essential is at risk (e.g. when being overruled by CPAS – OCMW doctor).

5.3.1.6 Procedures granting undocumented migrants access to urgent medical aid: perspectives of CPAS – OCMW

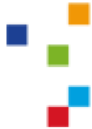
Strengths

With respect to the involvement of the CPAS – OCMW in approving UMA, key informants highlight that the CPAS – OCMW also serve other people seeking aid and that there is thus low risk of stigmatizing UM. Furthermore the UMA system is geographically well spread and practically accessible for people living in small towns or villages because CPAS – OCMW are located everywhere. HCP observe that goodwill is present in CPAS – OCMW staff to accept specific justifications (e.g. 'sleeps on a public bench' as address) or to personally visit the patient when being hospitalised so that procedures can be activated. Some CPAS – OCMW have made access to UMA easier which is highly appreciated by undocumented migrants who are in the system for long time.

Weaknesses

Key informants detect several weaknesses in the system at CPAS – OCMW level, especially concerning the social enquiry of indigence, with subjective assessments or different interpretations of the procedures among CPAS – OCMW because of territorial jurisdiction. Moreover the social enquiry of indigence and the enquiry of territorial responsibility require (enormous) efforts from CPAS – OCMW in terms of time and human resources. Other weaknesses of the procedures that the CPAS – OCMW themselves are exposed to are e.g. the limited duration (45 days) for CPAS – OCMW to take a decision after the care has been provided or the impossibility to approve UMA for more than 3 months. Undocumented migrants reveal that CPAS – OCMW refuse UMA due to administrative reasons (stated as 'not complying with conditions to receive UMA') or because health care was deemed not necessary, but that often no explanations are given. This is confirmed by

[kk] The system of a consultation vouchers works as follows: every patient who arrives at the emergency department or policlinic and who is not known or does not have financial means is given a consultation voucher at check-in and is seen by a doctor who then must indicate the type of care needed. Three types of care and subsequent steps are: 1) patient is referred to emergency care because there is no reason to impede, avoid or delay care; 2) care is necessary but this can wait a maximum of 10 days, so the patient is then seen by a hospital's social assistant who will help with paper work to obtain medical card; 3) one consultation is given, but patient could have been treated at first line and this is explained to patient who is brought into contact with GPs in the neighbourhood and urged to arrange paper work to obtain medical card.



HCP who also experience that CPAS – OCMW overrule the decisions of health care providers to start essential treatment.

Opportunities

Key informants see opportunities for CPAS – OCMW in simplification of the UMA system by e.g. modifying the government guidelines to enable CPAS – OCMW to elaborate a smoother and faster system for access to primary care, allowing them to provide a medical card for a longer period (e.g. 1 year) and/or a preventive medical card[ll] or by extending the duration to notify (nowadays 45 days). Harmonisation of the application of UMA procedures between the CPAS – OCMW is also considered an opportunity, as well as making another political body responsible for UMA. Undocumented migrants confirm that CPAS – OCMW do not check their address anymore which is seen as an opportunity for easier approval of the medical card and better provision of care as well. HCP suggest that full respect of roles and responsibilities of each party involved would create less ambiguity in decisions on urgent medical aid, but that there should always be a possibility of submitting a rebuttal and not letting incorrect refusal by CPAS – OCMW pass by.

Threats

Key informants regret the absence of a control body for the application of UMA procedures by the CPAS – OCMW, because this results in different practices and possibly differences in interpretation of the regional responsibilities. According to HCP undocumented migrants are not getting the medical care they are entitled to due to CPAS – OCMW not sticking to their role and not implementing the law correctly. Even with a functional MediPrima system, the CPAS – OCMW remain the intermediary level between UM and health facilities and discretionary decisions remain thus possible.

5.3.1.7 Procedures granting undocumented migrants access to urgent medical aid: perspectives of supporting NGO practices[mm]

Note: This topic was not brought forward in the SWOT of the undocumented migrants and the SWOT of the focus group discussions.

Strengths

Key informants notice that the strength of NGOs lies in their flexibility to adjust to the changing and evolving legislation for UMA.

Weaknesses

Substantial efforts in terms of financial and human resources are required from supporting NGOs to activate and monitor all UMA procedures. Moreover this is judged costly by key informants.

Opportunity

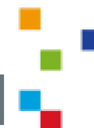
Key informants assume that (stronger) partnerships between supporting NGOs and CPAS – OCMW could be beneficial to undocumented migrants.

Threat

If the right to UMA for undocumented migrants is not activated by those responsible for it, according to key informants this could result in saturation of the currently highly accessible services of supporting organisations.

[ll] This is a medical card for preventive services even before care is needed.

[mm] Given that NGOs are mostly no direct actors in providing UMA to UM, this aspect was less elaborately discussed in the interviews and the focus groups.



5.3.2 Provision and quality of urgent medical aid for undocumented migrants

5.3.2.1 Reachability of urgent medical aid for undocumented migrants

Strengths

Urgent medical aid is deemed reachable by key informants because health care is provided to UM wherever possible and through the regular health system. Undocumented migrants themselves add the well-performing referral system to this because the UMA procedure can be initiated by the health professional/service, public social and health services generally refer to the adequate service, and there is appropriate referral between social and health services. HCP applaud that the referral in between services of the same health facility facilitates access to urgent medical aid as well.

Weaknesses

Observed constraints to reachability of urgent medical aid by key informants are - at CPAS – OCMW level - the reimbursement of UMA expenses being limited to INAMI – RIZIV nomenclature code or not having a fixed contact person in Brussels because of unclear allocation of social workers across the 19 CPAS – OCMW, and - at health care level - the geographically limited choice because of health care providers being far from UM’s residence, difficult access to emergency care in hospitals, or waiting lists for transplantations. Undocumented migrants identify several temporal aspects related to UMA procedure as weaknesses because of length of the procedures, long waiting time in health and social services, limited opening hours or specific time slots at CPAS – OCMW, or need to come several times to CPAS – OCMW for one single procedure. HCP confirm that the procedures are too long, both for the UM in need of care as for the health facilities involved, before being able to start up treatment, thereby hampering correct treatment and adherence of UM.

Opportunities

In terms of reachability key informants suggest that health care provision for undocumented migrants should be aligned to that for asylum seekers in asylum reception facilities. Undocumented migrants indicate that NGOs and their own informal network, friends and family are the most important agents of support when accessing social and health services. In this respect HCP propose that arrangements for UMA could be made by phone or online, with support from the mentioned agents, because it is time-saving for all parties involved and reduces negative temporal aspects related to UMA procedures.

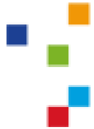
Threats

Key informants assess that a separate health care system for undocumented migrants (e.g. dispensaries) could put the quality of care provided at stake. Undocumented migrants themselves judge that being referred from one service to another without being cared for (for social and/or health issues) has implications for their health status and – as confirmed by key informants and HCP - in some cases for public health too (e.g. no vaccinations, no proper treatment of TB). The length of the UMA procedures is hampering correct treatment and adherence of UM and also jeopardising the UM's health status, even endangering their life (depending on the health condition).

5.3.2.2 Functionality of urgent medical aid for undocumented migrants

Strengths

The fact that health care can be provided without having to wait for activation of UMA (i.e. control by CPAS – OCMW comes afterwards) and without prosecutions is considered useful by key informants. Undocumented migrants appreciate that the health care package is often adapted to their specific situation (e.g. pregnancy, chronic diseases) and that some CPAS – OCMW give autonomy to freely choose health care professionals/services (e.g. primary care or pharmacies). HCP endorse these strengths and complement them with health facilities offering medical care without knowing whether they will be refunded and assuring continuity of care is assured through e.g. internal referral in between services or providing medication from proper pharmacy stock to improve effective treatment.



Weaknesses

Key informants regret that access to a prescribed treatment is not possible as long as the right to UMA has not been activated, that the complexity and scope of the administrative procedures influence the timely provision and quality of care, and that the reimbursement of the first medical consultation (if this was conducted before UMA application) is variable due to subjective and incorrect interpretations of social assistants with respect to relevance of care. Undocumented migrants mention that continuity of care (between two procedures or between two episodes of disease) is hampered by two factors: 1) the need to renew the application for UMA every 'x' months, and 2) the lack of coordination between primary care and hospital services, between CPAS – OCMW & pharmacists, or between health professionals in the same hospital. Some undocumented migrants perceive a limited autonomy for not being allowed to freely choose their health care professional/service. Health care professionals and managers CP notice that UMA coverage is not the same across Belgium which leads to unequal treatment of undocumented migrants. They also confirm that continuity of care is at stake due to the slow process and possible delay in getting the medical card and when UM are discharged from the hospital because 'after care' cannot be offered (because this is not being not reimbursed or too expensive because of private services).

Opportunities

Key informants suggest that the establishment of networks of organisations that support undocumented migrants could improve efficiency and that the commitment of health policy-makers to emphasise the social function of (intercultural) mediators could be beneficial to UM seeking health care. In terms of continuity of care UM see a possibility in an automatic extension of the validity of the medical card (more than 3 months). Focus groups participants see opportunities for improving the functionality of UMA by providing standard extended coverage for vulnerable groups in specific situations (e.g. pregnant women, newborn children, children), by guaranteeing the medical card to the complete household, and introducing a consultation voucher (see above) in hospitals.

Threats

According to the key informants, the lack of informal care (at home) or an informal support base hampers full treatment (including for example care after hospitalisation, adherence to medication). Undocumented migrants notice that non-inclusion of social determinants of health (e.g., housing, food, transportation) in UMA could jeopardise the effectiveness of the provided medical treatment, which is reaffirmed by HCP stating that vulnerable groups such as pregnant women and newborn children could get into worse or even life-threatening health situations if not provided with appropriate care.

5.3.2.3 Availability of urgent medical aid for undocumented migrants

Strengths

In terms of availability key informants stress the importance of all patients being helped/treated in the same way, undocumented migrants show appreciation for the free choice of health care provider, while HCP see the referral to a limited number of services (cf. lists of doctors and pharmacies) as a way of reducing the time they need to invest to find proper care and of guaranteeing a health care provider who is also administratively able to take care of them and who knows the UMA procedures.

Weaknesses

Difficulties in accessing care/treatment without nomenclature code, inadequate provision of care for unaccompanied minors (e.g. chronic diseases, personal development of the child, psychiatric disorders), or (imposed) allocation of health professionals by CPAS – OCMW (with risk of either specialisation or generalisation and risk of reduced quality of care) are considered to weaken availability of urgent medical aid according to key informants. UM judge that the availability of health care is limited because choice of health services/professionals is made by the CPAS – OCMW themselves or based on their list, because the CPAS – OCMW preferentially address patients to integrated health services (e.g. community health centres such as 'Maisons Médicales' or 'Wijkgezondheidscentra'), or because of denial/referral by the health care services themselves. Health care professionals and managers share these observations.

Opportunities

The available goodwill among professionals and organisations to collaborate, in order to offer UMA to undocumented migrants, is considered an opportunity by key informants. Financial incentives or motivation for the ("imposed") health care providers could be deliberated to maintain a high degree of quality of care. UM confirm that, if they could freely choose health services/professionals everywhere, they would experience more availability of urgent medical aid. Health care professionals and managers seek opportunities for improved availability in the simplification and standardisation of UMA procedures. If simplified administration is not feasible, the establishment of a multidisciplinary "focal point" or a "referral centre for UM" could be considered, combining administrative (CPAS – OCMW tasks now), judicial, psychosocial and medical aspects at one spot.

Threats

Key informants fear that the administrative burden due to saturation of primary health care facilities could result in saturation and thus non-availability of health care providers. They repeat that modification of the legislation and the Royal Decree of 12 December 1996 could imply a reduction of the currently available provision of urgent medical aid. Health care professionals and managers recognise that the consequence of establishing a focal point or referral centre (see opportunities) might imply a too heavy burden on public hospitals.

5.3.2.4 *Knowledge of urgent medical aid for undocumented migrants*

Strengths

Familiarity of public health care facilities with the UMA system guarantees quality of care according to key informants, while the good reputation of the health care providers themselves (e.g., being excellent in specific medical areas, being helpful towards undocumented migrants) influences help-seeking by undocumented migrants. Health care professionals and managers consider the information, support and/or referral by social services and non-governmental organisations to access UMA to strengthen knowledge of UMA.

Weaknesses

Knowledge of urgent medical aid is seriously hampered by lack of information and communication for both UM and health professionals. In addition, HCP point at the misperception of the general public, health professionals and policy makers on the number of undocumented migrants who are seeking health care in Belgium ‘for free and should be considered medical tourists’ as a serious weakness.

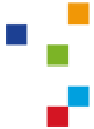
Opportunities

Key informants propose to give an explanation about the Belgian health system and services accessible to UM within the societal integration courses[nn], and to include information about the content and procedures of UMA in the curricula of health care providers. NGOs act as intermediary between UM and mainstream (health) services, and are seen by undocumented migrants as enablers to get access to UMA (but presence of an informal network is perceived as the best enabling factor to provide information about mainstream health services, NGOs, and rules/procedures to get urgent medical aid). HCP hold health facilities responsible to guarantee, as an indicator of quality, that the patient is well-informed, and, if needed, assisted in his/her proper language to enhance knowledge. Training of health professionals and availability of innovative information tools on current UMA definition and procedure are also opportunities for increasing knowledge.

Threats

The existing reluctance among health care providers because the content and procedures of UMA are not always well known and the improper use of emergency services by undocumented migrants because both the Belgian health system as the UMA procedure are not sufficiently known are possible threats mentioned by key informants. Medical tourism to cities where CPAS – OCMW and health care facilities are known to cover more services could

[nn] However, since undocumented migrants are not allowed to follow these courses, this option is not feasible nor useful.



imply extra (administrative and financial) burden for those CPAS – OCMW and health facilities according to HCP.

5.3.2.5 Affordability of urgent medical aid for undocumented migrants

Strengths

According to the informants affordability of urgent medical aid is assured through the broad package of (reimbursed) care being offered to UM. Focus groups participants applaud the high affordability and hence accessibility of community health centres. They also mention that primary health facilities and target-group specific health services, such as ONE/Kind & Gezin, refer to health care providers who have agreed to work at an affordable 'reduced fee' (e.g., gynaecologists, GP sentries, laboratories) when saturated or when specialised care cannot be offered. The (financial, administrative, psychological) support from (non-governmental) organisations facilitates their access to health services and_social services according to undocumented migrants.

Weaknesses

Only reimbursement of medical care while availability of accommodation and food has implications on the treatment (e.g. malnutrition, street life) is a fault in ensuring affordability according to key informants. Barriers to affordability identified by UM at the health service level are:

1. Some acts/treatments are not covered by the CPAS – OCMW (e.g., medication),
2. Some pharmacies refuse delivering medication if the UM do not pay beforehand or refuse being charged by the CPAS – OCMW,
3. Health professionals refuse providing care because of the uncertainty or delays in reimbursement, and
4. UM have to pay beforehand.

For undocumented migrants themselves, barriers related to affordability are

1. Not being able to afford health care fees, and
2. Additional fees or co-payments are not reimbursed (e.g., patients are seen by specialists outside convention with INAMI – RIZIV).

Health care professionals and managers notice that health professionals and facilities refuse providing care or medication for financial reasons:

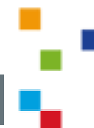
1. UM cannot pay an instalment upfront or cannot bear the full costs or extras in case of a non-conventionalised specialist,
2. Delays in reimbursement by CPAS – OCMW up to 6 or more months,
3. Uncertainty whether CPAS – OCMW will accept the full treatment and reimburse correctly, and
4. Not all treatments/acts are covered by the list used by CPAS – OCMW.

Opportunities

Possible facilitators to make UMA affordable for undocumented migrants at health service level are diverge: 1) payment by capitation would make the system more equal, just and feasible in a timely manner; 2) the first consultation could be for free or embedded in a consultation voucher; 3) giving the right for indefinite time to health insurance coverage through mutuality from the moment a person resides on Belgian territory could be considered, or 4) universal health coverage could be considered at least at European level to start with.

Threats

Health care professionals and managers perceive the risk that an "all-patient-diagnosis-related groups" funding system (as is the case for hospitalisations) is going to be installed for urgent medical aid for undocumented migrants which could induce 'health care at several speeds'. The potential tension between goodwill of staff to provide support and care on the one hand and the increasing cost of UMA for health facilities on the other hand (because not all services are being reimbursed or only with significant delay so that Board of Directors puts pressure on staff) threatens the affordability of urgent medical aid.



5.3.2.6 Reliability of urgent medical aid for undocumented migrants

Strengths

According to key informants public health care services are familiar with the system so that quality of care is being guaranteed in the same way as for persons with health insurance. UM appreciate that health care providers first provide care and treatment, and only afterwards take care of administrative aspects. Following attitudes have been cited by them as positive in the relationship with and reliability of health professionals: 1) empathy, kindness, attention and respect, 2) ethnic concordance/matching, 3) equal treatment regardless of UM status, and 4) no stigmatisation, stereotyping or labelling. UM also express their satisfaction with the care received and their gratitude to the Belgian government and to the CPAS – OCMW. Health care professionals and managers observe that social assistants (at CPAS – OCMW or at health facilities) and health professionals do not differentiate between undocumented and documented migrants/citizens and provide the same package and quality of care to all, regardless of the status or any other characteristic one can have.

Weaknesses

The *a priori* limitation of the role and radius of action of organisations supporting UM hampers reliability and is not in favour of social determinants of health according to key informants. UM report negative attitude towards:

- social assistants at CPAS – OCMW due to:
  a) Lack of empathy, kindness, attention, respect,
  b) Holding back or providing incorrect information, and
  c) Administrative errors;
- health professionals because of
  a) Absence of systemic approach to UM and family,
  b) Lack of privacy,
  c) Many administrative errors and some medical errors, and
  d) Reluctance to care for UM;
- both social assistants of CPAS – OCMW and (to lesser extent) health professionals because of
  a) Stigmatisation, patronising, belittling, excessive familiarity, and
  b) Different attitude/treatment when UM is accompanied by professional/volunteer from supporting organisations.

For health care professionals and managers, the decision-making process on provision of UMA or not is flawed by:

1. Health professionals not wanting to sign the statement that the care is medically considered as UMA even though according to the law it should be considered as such,
2. CPAS – OCMW scrutinising every decision or step taken by every actor exceeding the necessary level of control,
3. CPAS – OCMW overruling the decision of the health professional stating that it cannot be considered UMA, and
4. Discretionary decisions among CPAS – OCMW or among staff of same CPAS – OCMW on what is considered UMA or on extra coverage for some treatments/interventions/medications.

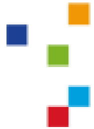
Opportunities

According to key informants the establishment of a broader network of supporting organisations could lead to better coordination, more efficiency of support given to undocumented migrants and thus increased reliability. For undocumented migrants it is essential to discuss openly and if necessary report any breaching of the UMA legislation both at the level of what UMA entails (preventive and curative care) as at the level of roles and decision-making power.

Threats

Key informants see possible threats in reliability with respect to the professional secrecy of health care providers (while medical certificates need to mention the medical diagnosis and are addressed to non-medical users) and protection of privacy of undocumented migrants not always being guaranteed. Barriers to reliability at patient level are due to:

1. Mistrust of social assistants or health care professionals vis-à-vis undocumented migrants,
2. Anxiety,
3. Feeling that everything was scrutinised by the CPAS – OCMW, that everything should be justified, or that controls were excessive,



4. Racism, and
5. Fear of asking information.

According to HCP the current level of discretionary decisions taken at the CPAS – OCMW as well as at the health facilities breaches the right of undocumented migrants to health and health care.

5.3.2.7 Comprehensibility of urgent medical aid for undocumented migrants

Strengths

According to key informants good practices help to inform undocumented migrants about UMA (e.g. websites, leaflets, specific units for UMA) and to enhance health literacy and comprehensibility. UM appreciate that health care providers and facilities make efforts to communicate in a common language. Health care professionals and managers applaud the substantial efforts made by staff from social and health services or from supporting organisations to sensitise, inform, and empower undocumented migrants to get access to UMA. They also appreciate the increased offer of interpreters and/or intercultural mediators in (large) health facilities for improved information-sharing and communication.

Weaknesses

Language barriers and limited access to free interpreters hamper comprehensibility seriously according to key informants. Undocumented migrants confirm that they experience communication problems due to language barriers, both at CPAS – OCMW or in health facilities. Health care professionals and managers notice difficulties in social workers at CPAS – OCMW but also staff in health facilities being correctly informed and continuously updated on new aspects of UMA procedures.

Opportunities

If full access to interpreters, better diagnosis and care could be provided and unnecessary health care costs could be avoided. Availability of easily accessible/downloadable leaflets with the most common health complaints in most common languages would increase comprehensibility of UMA for undocumented migrants.

Threats

Reluctance of doctors to treat undocumented migrants because of language barriers hampers provision of care. Health care professionals and managers point out that not all individual GPs can afford to understand all UMA procedures and rules (and to arrange the administrative burden).

5.4 Cross-cutting themes

When analysing the legal and political frameworks as well as the seven core elements of the quality of provided care, four cross-cutting themes emerged:

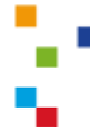
1. Definition of urgent medical aid;
2. Information and communication;
3. Application of procedures; and
4. Decision-making processes.

These four themes do not only transverse the legal and political frameworks as well as the quality elements of provided care, they can also be identified as key knots linking the most important problems and challenges in the current implementation of urgent medical aid for undocumented migrants in Belgium. Both undocumented migrants as well as health care professionals and managers suggest ways in which these knots could be untied. We hereby first present the four areas of challenges and problems:

1. Lack of a clear definition of urgent medical aid;
2. Lack of information and communication;
3. Complexity of procedures; and
4. Discretionary decisions.

Thereafter, we will discuss the potential solutions as suggested by the participants for the same four cross-cutting themes:

1. Clear definition of urgent medical aid;
2. Adequate and accurate information and communication;
3. Simplification of procedures; and
4. Appropriate decisions.



5.4.1 Four areas of challenges and problems

5.4.1.1 Lack of a clear definition of urgent medical aid

A first cross-cutting theme that is linking many other challenges and problems is the **definition of urgent medical aid** itself. Above all, **the word "urgent"** is considered as an extremely confusing element. For many participants in this study, this word is interpreted in the sense of "emergency" care, while this is not what is stipulated in the legal description of what urgent medical aid entails.

> *« Ik denk dat "dringend" al een probleem is voor vele artsen, omdat zij vinden dat het niet dringend is terwijl wij dan komen aandraven met het foldertje van Medimmigrant, dat duidelijk uitlegt van, kijk, het is niet altijd in de dringendheid maar het is ook op het curatieve, preventieve vlak, en dan begint het verhaal, dan is er discussie van waar stopt het en waar begint het. »*
>
> Quote retrieved from a focus group

> *« Je dirais qu'elle porte très mal son nom. Ça fait penser à ambulance donc il faudrait lui donner un autre nom parce que la notion d'urgence dans cette procédure est toute relative. Ça devrait être requalifié pour que quand on en parle on sache exactement de quoi il s'agit. (…) surtout pour ceux qui travaillent dans les urgences, ça amène la confusion. Il faudrait une dénomination plus juste pour qu'il n'y ait plus de confusion. »*
>
> Quote retrieved from a focus group

This semantic ambiguity impacts the health-seeking behaviour of undocumented migrants who might consider their health problems as not being a matter of "life and death" and therefore not seeking the care they need and which they are entitled to.

> *« What does it mean? Do I have to fall dead first? »*
>
> Quote retrieved from an interview with an undocumented migrant

This also impacts the decision-making process at the health care providers' side, who are now often forced to consider whether the health problems of the undocumented migrants are to be qualified as 'in need of emergency care' or not.

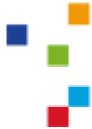
> *« Moi en théorie ça me gêne un peu cette histoire d'aide médicale urgente parce que ça veut dire que c'est une restriction des droits. Ça veut dire qu'y a des gens qui n'ont droit qu'à certaines choses qu'on va qualifier d'urgentes, avec tout le flou que ça implique. Pour moi c'est très gênant, en tant que médecin et en tant qu'être humain, mais en tant que médecin c'est encore plus gênant. J'ai du mal à dire ce que j'entends par aide médicale urgente car pour moi ça ne veut pas dire grand-chose. Ça veut dire qu'on va réduire quelque chose à l'urgence mais dans la pratique c'est impossible ça n'a pas de sens. »*
>
> Quote retrieved from a focus group

The fact that health care providers do not consider health problems as requiring emergency care implies that they do not sign the document stating that the care qualifies as "urgent medical aid" which eventually results in not providing care or in suboptimal provision of care.

> *« Now they just prescribe me medication instead of surgery because the specialist refuses to sign UMA paper »*
>
> Quote retrieved from an interview with an undocumented migrant

The wide variety of interpretations of "urgent" is also reflected at the side of the CPAS – OCMW: they might have a divergent opinion on this, which results in not accepting to cover the suggested treatment and/or provided care.

> *« Y a le problème avec les maladies chroniques aussi, alors le CPAS – OCMW ne veut plus considérer que ça fait partie de l'aide médicale urgente. C'est idem pour les classes de médicaments, certains ne sont pas remboursés mais ils sont pourtant nécessaires. »*
>
> Quote retrieved from a focus group



A second semantic aspect of the definition that is causing confusion is **the word "medical"**. For many undocumented migrants, but also for many social assistants at CPAS – OCMW, this is merely interpreted as physical health problems requiring medical care in the form of medications and/or physical interventions. This means that mental health problems are often ignored.

> *« Cela me travaille toujours l'esprit la nuit, j'ai des cauchemars. Je ne peux pas rentrer au pays : ils vont me chercher, j'ai des enfants maintenant, et en plus il n'y a pas le bon traitement pour le VIH. (…) Mais il faut toujours garder le moral, je ne suis pas mal dans ma tête. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« Ik houd me sterk uit noodzaak, maar psychisch, daar ga ik zelfs niet over spreken. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« On a aussi des situations où plusieurs pharmacies refusent de donner le médicament avec le système de remboursement dans le cadre de l'aide médicale urgente. On a téléphoné aux pharmaciens, on a demandé aux patients d'y retourner. Donc c'est problématique. Y a des médicaments psychiatriques qu'il faut absolument prendre donc c'est dangereux. »*
>
> Quote retrieved from a focus group

Furthermore, this interpretation reflects a **narrow definition of health** as being the absence of disease and/or infirmity and neglects necessary preventive and health promotion actions that are evidenced to prevent an outcome of worse health. This is for example the case in pregnancy health or health of new-borns, whereby some treatments or supportive actions are not being offered or covered by the CPAS – OCMW to undocumented migrants, because they are considered as not to be covered by UMA. These findings confirm earlier evidence of policy frameworks on migrant sexual and reproductive health care being limited to disease-oriented care which may lead to worse health if a third actor does not decide to cover for the costs or if the migrant pays of his/her own pocket.[45, 46]

> *« On parle souvent de médicaments mais si on élargit à soins, soins préventifs, soins curatifs, en matière de grossesse notamment, pour les suivis on n'a pas toute la liberté pour faire les examens. L'ONE doit prendre en charge des tas de choses comme des prises de sang pour qu'il y ait un suivi parce que ce n'était pas pris en charge dans l'aide médicale urgente. »*
>
> Quote retrieved from a focus group

> *« So for the first 3 months (from my 5th till 8th month of pregnancy), I had to pay for myself. Luckily, my boyfriend and friends often supported me and paid the bills, but without their support, I don't know how I would have done that, I can imagine that some people don't go then". »*
>
> Quote retrieved from an interview with an undocumented migrant

Moreover, both undocumented migrants and health care providers emphasise that the lack of a clear definition of urgent medical aid fuels the ambiguity on which types of health issues are covered by one CPAS – OCMW and not by another, which subsequently stimulates undocumented migrants who have the means **to hop from one city to another**, which eventually results in unequal treatment for the same health condition.

> *« "I recognised symptoms (of HIV), I went to a GP in [X]. It was a good doctor and he said that he would send me to OCMW from [X]. But, the social assistant there said: "You are sick you should go to your home country!" This was a bad social assistant, but it's not a fixed social service, so the next one was better, and she sent me to the ARC (Aids Reference Centre) in [Y]. I now live in [Y], and my medical card is renewed every 3 months without a problem. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« "Het OCMW van [X] heeft een positieve aanpak daarrond: dat ze op preventief vlak werken met patiënten, en ze doen een terugbetaling voor kinderen tot 18 maanden, en ze betalen ook voor de maaltijd op school. »*
>
> Quote retrieved from a focus group

Finally, the definition of urgent medical aid is only applicable to UM living in Belgium. Several health care providers stress that this causes problems with **European migrants** who flee economic crisis or poverty in their European country of origin and who are staying here without being covered anymore by any insurance. The fact that they are excluded from UMA creates confusion to health care providers as well as to migrants who might not be aware of alternatives.

> *« Y a aussi la question de « ne faisant pas partie des pays européens ». Parce que là y a un flou, notamment pour les Roms, les Roumains, les Bulgares, les Portugais. Même des Espagnols ou des Marocains qui ont vécu en Espagne et qui remontent. […] Les CPAS – OCMW font une distinction entre les pays européens et le reste dans la disponibilité des soins. »*
>
> Quote retrieved from a focus group

5.4.1.2 Lack of information and communication

Another cross-cutting theme can be labelled as **lack of information and communication** which hampers the provision of care and the UMA coverage. These information and communication issues occur at the level of all stakeholders and lead to different problems and challenges.

First of all undocumented migrants emphasise how **little information is available to them** on how the UMA procedure works, where they have to turn to when seeking care and which different steps in the procedure are to be followed. They state that they had to learn by doing, which equalled quite often being sent back to the CPAS – OCMW for the necessary paperwork, being refused care, or needing to undergo endless procedures, having to wait months before obtaining the UMA card, etcetera. This regularly results in stress, miscomprehension and late provision of care.

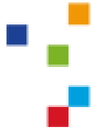
> *« In my home country you go to a clinic and even though you may wait a long time, you will see a doctor. Here, you first have to know where to go and when to go. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« Een nadeel is misschien dat nog altijd mensen de weg niet kennen, en er nog altijd situaties zijn van mensen die vaak te laat maar weten dat ze kunnen komen, dat ze kunnen consulteren, zelfs zonder geldige papieren. »*
>
> Quote retrieved from a focus group

> *« I'm used to long waiting, but with my illnesses I can't wait or I die. »*
>
> Quote retrieved from an interview with an undocumented migrant

Health care providers moreover state that provision of information on health related issues as well as accessibility of the health care system is hampered by the **limited health literacy** that some migrants have. Some of the interviewed undocumented migrants confirm this for certain issues, especially for sexual and reproductive health as well as for specialist care, but others just state the opposite, emphasising that their general health literacy is a supportive element in accessing care and UMA.

> *« Je ne sais rien non plus sur les méthodes contraceptifs : lesquels? Je pense que c'est nécessaire pour être sur ce qui est vrai ce qui n'est pas vrai sur la grossesse, j'essaie de trouver moi-même par internet, mais je ne suis pas sûre. »*
>
> Quote retrieved from an interview with an undocumented migrant



« Bij hoofdpijn of migraine neem ik pijnstillers zoals Dafalgan, ik ga niet direct naar de dokter bellen, soms ga ik naar huisarts. Als het over kinderen gaat, ga ik sneller naar de dokter (altijd huisarts), of de ambulance bellen want dan begin ik te panikeren. Mijn moeder is ook dokter en ik weet wat gevaarlijk is en wat niet. »

Quote retrieved from an interview with an undocumented migrant

Also at the side of health care providers, it is demonstrated that they often lack the knowledge and literacy about what UMA entails, how the procedure functions and to what care and treatment they are (not) entitled.

« Wij hebben tijdens de opleiding nooit geleerd wat dringend medische hulp is. »

Quote retrieved from a focus group

« Ik ga gewoon naar de apotheek met het voorschrift, maar ik krijg alleen wat er op de lijst staat, sommige dokters denken er aan, andere niet. Ze weten het ook niet allemaal wat op de lijst staat. »

Quote retrieved from an interview with an undocumented migrant

« Personeel [van het OCMW], dat is het probleem, want zij weten niet het nieuwe regelement van het OCMW van [X]. Elke zes maanden of zo veranderen ze het reglement, maar de andere mensen weten niks, ze blijven met het oude reglement. Als je komt met het nieuwe regelement zeggen ze: 'Nee, dat is niet meer geldig'. Ik zeg: 'Dat is niet waar', maar ze weten het niet. »

Quote retrieved from an interview with an undocumented migrant

All parties involved also indicate that health care providers are rarely aware of where to find information about urgent medical aid if it was not provided by the social service of the hospital itself.

« Il y avait une infirmière qui se doutait de mon statut, j'étais là avec le bébé et elle a posé plein de questions, est allé demander à des collègues, puis l'assistant social a dû venir pour rassurer, j'étais énervée, tout est dans mon dossier, j'ai demandé si c'était possible de voir une autre vu qu'il était temps de changer des shifts. Maintenant je vais directement au laboratoire pour une prise de sang et pour ne plus voir cette infirmière. Maintenant, ça va. »

Quote retrieved from an interview with an undocumented migrant

« Ik probeer de arts eens op te bellen en te vertellen dat patiënt die medicatie niet kan krijgen van het OCMW en vaak bestaat er een alternatief. Artsen zijn het gewoon om met een merk te werken. »

Quote retrieved from a focus group

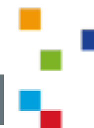
Another element that was brought up by both undocumented migrants as well as the healthcare providers relates to CPAS – OCMW **not informing nor communicating the justification of their decision** to refuse care or treatment of an UM. They do not provide this information to the migrants nor to the health professionals whose decisions about treatment are sometimes overruled by the CPAS – OCMW, an issue that many healthcare providers consider as inappropriate, offensive and against the law.

« Non. Ils n'ont pas dit pourquoi au CPAS – OCMW, ils ont juste dit ils ne prennent pas. Mais je crois que dans notre situation il faut tout le temps chercher l'information. »

Quote retrieved from an interview with an undocumented migrant

« Le médecin avait prescrit 4 séances par semaines, il a fait tous les examens possibles même une ponction du cœur, mais le CPAS – OCMW a dit: '2'. Le médecin était tellement furieux. »

Quote retrieved from an interview with an undocumented migrant



« De quel droit le CPAS – OCMW va contre une décision médicale et qui aura la responsabilité en cas de problème ? Quels sont les critères ? Qui prend la décision ? Au CPAS – OCMW c'est un médecin contrôle ? Est-ce qu'il s'agit de standards décisionnels ? C'est interpellant qu'une prescription médicale soit contrée. »

Quote retrieved from a focus group

« De wet zegt dat enkel en alleen de behandelende arts oordeelt of de zorg een toepassing is van dringende medische hulp. »

Quote retrieved from a focus group

Some respondents also mention the **absence of a notice of receipt** or other administrative 'proofs' when applying for UMA although the Law of 1976 related to CPAS – OCMW states the obligation of giving receipt notices.[oo]

« Want ze zijn het eigenlijk verplicht om het op het OCMW te geven, zo'n papier met de datum erop. Maar heel veel mensen weten het niet en doordat ze het niet weten, zijn ze ook niet assertief genoeg om het te vragen. Ik zeg ook altijd, je moet het vragen, om een bewijs te hebben om te klagen na een maand, als je geen beslissing hebt. »

Quote retrieved from a focus group

« Dus, als wij een patiënt responsabiliseren om naar het OCMW te gaan, het kan zijn dat die een drempel vormt, dan geven wij een papier mee waarin wij beleefd vragen aan het OCMW om toch een "accusé de réception", dus een ontvangstbewijs, af te stempelen zodanig dat wij weten dat het op gang is. Voor ons is het belangrijk om die datum te hebben, zodanig dat we dan dat kunnen bijhouden in een vervaldagboek bij manier van spreken, van kijk die patiënt heeft dat binnengebracht op die datum, we mogen ongeveer vier weken later naar het OCMW een belletje doen, en vragen hoe ver staat het met het verslag van jullie, hebben jullie daar het nodige voor gedaan? »

Quote retrieved from a focus group

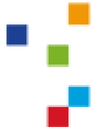
« Ik heb het (ontvangsbewijs) zelfs in een kleur, in een roze kleur, gemaakt, van kijk, het roze document moeten we terug hebben met de datum op, zodanig dat het voor een patiënt duidelijk is dat hij dit weer terug moet hebben. »

Quote retrieved from a focus group

Finally, as for information-sharing, all focus groups mention the fact that the CPAS – OCMW might ask for more information about the health condition of the UM or about the estimated costs of the treatment required before considering granting the UMA card, and, subsequently, reimbursement. This is another element of the CPAS – OCMW trespassing their authority and responsibilities. Several health care providers consider this a breach of the medical professional secrecy, something which they should not tolerate. According to the Belgian Code of Deontology of Medical Doctors[pp], a medical doctor is supposed to transfer information related to a diagnosis or a treatment in 4 circumstances: 1) to the legal representative of a patient in incapacity / being unconscious; 2) to another medical doctor in case of a

[oo] Loi organique du 8 juillet 1976 des [centres publics d'action sociale. Chapitre IV. - Des missions du centre public d'aide sociale. Section 1ère. Art 58 §2. / Organieke wet van 8 Juli 1976 betreffende de openbare centra voor maatschappelijk welzijn. Hoofdstuk IV. - Taken van het openbaar centrum voor maatschappelijk welzijn. Eerste afdeling. Art. 58.

[pp] This is only one of the possible codes, treaties and convention that apply here.



juridical expertise; 3) to research institutes – anonymous declaration; and 4) to the members of the European committee for the prevention of the torture and other inhuman treatments[qq]. In 2009, the Council of the Order of Doctors acknowledged that, in some circumstances, the CPAS – OCMW may need information related to the health care needs of the patient. However, social assistants working in a CPAS – OCMW are not considered as "health care providers caring for the UM patients" and could not be included in the shared medical secrecy. Consequently, only necessary information in order to ensure health care and well-being of patients will be communicated at the CPAS – OCMW, preferably to a medical doctor or directly to the UM[rr].[47, 48]

> *« Ik vind dat soms moeilijk die extra informatie, want ik heb het in principe heel moeilijk om met een sociaal assistente te gaan uitbreiden over wat de medische problematiek is van een patiënt. Eigenlijk kan dat niet, maar aan de andere kant vragen sociale diensten in kwestie vaak die gedetailleerde medische informatie. Ik vind dat echt wel dansen op een heel slappe koord om te kijken tot waar je daar als arts mag gaan in het geven van medische informatie in een medisch dossier. »*
>
> Quote retrieved from a focus group

> *« Parfois on doit trahir le secret médical pour sauver le patient. Soit tu tombes sur une assistante sociale qui est un peu ouverte ou alors tu tombes sur une assistante sociale qui ne veut pas et t'as de la chance ou pas. »*
>
> Quote retrieved from a focus group.

> *« Un autre souci que j'ai c'est à propos du respect du secret médical. On doit remplir la fiche et les assistantes sociales les lisent et non les médecins conseils comme prévu. Pour moi ça, ça ne va pas du tout, on met des choses très sensibles, ça devrait rester dans le circuit médical. Ça ne devrait pas changer la façon dont l'assistant social intervient et accompagne les gens. Sur le plan éthique, il faut en tenir compte si on change la procédure. »*
>
> Quote retrieved from a focus group

Another important element is the way professionals communicate with undocumented migrants. This **communication** can be divided in several subtopics.

A first one regards **language barriers,** which are mostly brought up by health care providers. Only few undocumented migrants mention language barriers as a problem, some however state that they are very grateful if translation/interpretation is provided by the health care services. Others emphasize that language proficiency or the lack thereof might be used by social assistants of CPAS – OCMW as a discriminatory tool in the UMA procedure.

> *« La barrière de la langue est difficile aussi. Il faudrait imaginer qu'un médecin traducteur les accompagne parce que, parfois, on fait presque de la médecine animale. »*
>
> Quote retrieved from a focus group

> *« In city hall of [X], you have to speak Dutch, and if you don't, they treat you as a criminal, verbally "Sign here! Sign here! You are rejected!", so loud with a lot of people, I was completely sick. »*
>
> Quote retrieved from an interview with an undocumented migrant

qq Art 62 du Code de Déontologie Médicale, Ordre des Médecins / Art. 62 van de Code van Plichtenleer, Order van de geneesheren

rr See the recommendation a125004"Personnes en séjour illegal – Secret professionnel – CPAS – OCMW / Mensen die onwettig in België verblijven – Beroepsgeheim-OCMW"

> *« Met Dokter [X] gaat wel goed, het is makkelijk om met hem te spreken, met tolk (tolk die ook tolkt tijdens het interview): "ik kan daar mijn gedachten afmaken". »*
>
> Quote retrieved from an interview with an undocumented migrant

Furthermore, the majority of undocumented migrants stress how professionals communicate with them in a very **patronizing and belittling** way, demonstrating a **lack of empathy and respect**, Respondents link this disrespectful approach predominantly to the attitudes and behavioural skills of social assistants of the CPAS – OCMW. They give examples of positive treatment by doctors, albeit some also cited expressions of doctors and nurses revealing moral and or political opinions about migration and care.

> *« Le CPAS – OCMW, c'est trop difficile, ils jugent, ils ne sont pas gentils, et elle m'a dit "qu'est-ce que tu vas faire, tu es enceinte ! Quelle mère seras-tu ? »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« Le CPAS – OCMW ne te traite pas comme un être humain, pas en tant qu'égaux, sauf si Medimmigrant vient avec. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« At my first contact, he (the doctor) examined me, and patted my arm, told me not to panic, he was human, calming down, he was like a friend. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« I had one who had to check my blood, she asked: where are you from? What are you doing here? You have to go back to your country! She did not check my medical condition, so I went to the social service to say this, and then to a doctor, and then I was appointed another nurse. Well, some have talent, others not. »*
>
> Quote retrieved from an interview with an undocumented migrant

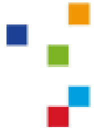
5.4.1.3 Complexity of procedures

The third cross-cutting theme is related to the **complexity of procedures**. Besides restricting access to health care for UM, the overall complexity of the UMA procedure constitutes an important barrier for HCP when delivering health care to UM. For example, solo GPs are less likely to be involved in health care for UM as the procedures are complex from an administrative perspective. In this section, we identify several components of the complexity for the UM and the HCP. The problems related to the definition and the communication issues described above contribute to the complexity of the procedures.

> *« Mais un généraliste qui travaille seul, c'est difficile car c'est extrêmement compliqué de s'y retrouver dans cette législation. »*
>
> Quote retrieved from a focus group

Firstly, **providing an address** is identified as an essential component of the complexity of the procedures. Indeed, both undocumented migrants and health professionals report situations in which the provision of an address constituted a major obstacle to get UMA.

> *« Après, elle m'a demandé l'adresse. Avant, je n'avais pas d'adresse, ils avaient mis 'sans domicile fixe'. Ils ont mis l'adresse d'une église. C'est comme ça qu'ils ont fait. Après, l'assistante qui s'occupait de moi est partie, le CPAS – OCMW m'a dit c'est obligé de mettre une adresse. Alors j'ai demandé à un ami si je pouvais mettre son adresse et il m'a dit : ça va. »*
>
> Quote retrieved from an interview with an undocumented migrant



Homelessness, precarious housing or being hosted by friends or family are situations in which providing an address is particularly difficult. Some UM report being afraid of the consequences of giving their address to the CPAS – OCMW for them or their relatives, i.e. reduction of social welfare allowances or fear of deportation.

> *« La femme ou je dormais ne voulait pas cela. Elle n'a pas de papiers non plus. La famille ne voulait pas non plus parce qu'ils avaient peur de la police d'héberger une personne sans papiers. »*
>
> Quote retrieved from an interview with an undocumented migrant

The magnitude and the content of the social survey add to the overall complexity: UM need to prove indigence and health needs. Everything has to be justified and documented in order to complete the UMA application. In some situations, declarations of the UM have to be officially confirmed by friends, relatives or NGOs. Moreover, requirements are likely to change over time, for both UM and HCP.

> *« Quand j'y suis allé, j'avais apporté tous les papiers qu'ils m'avaient demandé dans le courrier, combien je louais la maison, pour l'électricité, l'eau, l'aide de ma famille qui m'envoie de l'argent aux USA. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« Ils ont convoqué pour prouver que j'ai aucune ressource. Mes amis doivent signer des papiers pour prouver que c'est eux qui m'aident à payer mon loyer et pas moi. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« J'ai dû apporter des preuves de ce que je racontais, mes factures, mes paiements que j'ai effectuée seule, les plans de remboursement avec l'hôpital de [X]. »*
>
> Quote retrieved from an interview with an undocumented migrant

A second complex component of the UMA procedure, highlighted by both interviewed undocumented migrants and health care professionals and managers, is the **need to go first to CPAS – OCMW before accessing health services.** Once the UM needs medical care, some CPAS – OCMW require that the UM first presents himself/herself at the CPAS – OCMW before seeking health care. Consequently, provision of health care is delayed.

> *« Pour voir le docteur, je dois aller au CPAS – OCMW d'abord. J'ai des rendez-vous avec l'assistante. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« Dans le cas de grossesse par exemple avec un temps défini c'est ridicule. On pourrait économiser du temps et de l'énergie à tout le monde. Puis on a une maman qui arrive en fin de grossesse et on ne peut pas lui faire faire sa prise de sang tout de suite parce qu'elle doit aller ouvrir son droit. Et alors on ne voit pas dès le début de sa grossesse qu'elle est HIV…»*
>
> Quote retrieved from a focus group

Some UM also report that they had to meet the health professional first before being accepted as patient – no treatment is delivered during the first appointment, the health professional "assesses" the UM regarding his/her likelihood of becoming a patient. This practice is also reported by HCP.

> *« Même si je téléphone, ils [les soignants] veulent qu'on se présente »*
>
> Quote retrieved from an interview with an undocumented migrant

Coming several times to CPAS – OCMW for a single procedure is the third component of the complexity. This frequent situation increases the length of the procedure, but also its complexity, as the requirement to come back several times may be supplemented with additional requirements from the social assistants. This has severe consequences on the health status of the UM, especially in case of chronic diseases such as diabetes.

« Le médecin, il te donne l'ordonnance, tu peux pas encore aller à la pharmacie, tu dois encore retourner au relais santé pour prendre le ticket et revenir encore à la pharmacie. Et la pharmacie, elle va regarder encore si le papier il est pas bien signé, on te dit encore de retourner au CPAS – OCMW et, le lendemain, on te dit : « celui qui doit signer n'est pas là il faut revenir le lendemain encore », et, en fait, tu n'as pas pris l'insuline. »

Quote retrieved from an interview with an undocumented migrant

« Je dois d'abord aller au CPAS – OCMW et je prends deux papiers : un pour le médecin et un pour la pharmacie pour qu'ils marquent les prix de médicaments. Puis je vais à la pharmacie avec l'ordonnance et ils me donnent le papier avec les prix et je dois ramener ça au CPAS – OCMW. »

Quote retrieved from an interview with an undocumented migrant

When the CPAS – OCMW does not work with a system of medical card, the number of demarches is increased as well as the delay to access health care. Each time the UM needs health care, she/he has to apply for UMA at the CPAS – OCMW. Again, besides the burden of the procedure, it may have consequences on the health of the UM.

« Donc quand on n'a pas la carte santé et qu'on est malade, on va au CPAS – OCMW, ils nous donnent un papier et on va chez le médecin. Là le médecin nous donne une ordonnance et un autre papier qu'on rentre encore au CPAS – OCMW. On va à la pharmacie, ils nous remplissent un autre papier et même si je suis gravement malade je suis obligée d'encore retournée au CPAS – OCMW, et là ils nous donnent un papier pour que je rentre encore à la pharmacie et là je peux avoir les médicaments. »

Quote retrieved from an interview with an undocumented migrant

UM point out that the **need to renew the application every (x) months** adds to the complexity of the procedure. Some UM have to come back every week, while others have to come back every month to introduce a new application for or an extension of UMA. In some CPAS – OCMW, the renewal is conditioned by a new social survey on the resources of the UM.

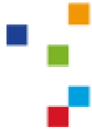
« Al veel verhuisd, we wonen nu sinds 6 maanden in dit huis, en er is al 2 keer iemand gekomen van OCMW, daarna niet meer, het wordt gewoon verlengd, nog nooit geweigerd in de 2 jaar dat we hier in [X] woonden, vroeger wel, maar dan niet in [X]. »

Quote retrieved from an interview with an undocumented migrant

« Donc à chaque trois mois il faut prolonger, les prolongations c'était un mois, le relais santé prolonge et après trois mois c'est l'assistante sociale, donc pour les trois mois, tu fais d'abord prolonger un mois par le relais santé puis deux mois par ton assistante sociale. […] Les deux premières années, quand on renouvelait chaque trois mois, on devait montrer tous ces papiers : le métier, les extraits de banque, l'adresse de mon frère, parce qu'on habite chez lui. »

Quote retrieved from an interview with an undocumented migrant

However, the medical card alone is not sufficient to decrease the **administrative burden** of the health services. Additional requirements by the CPAS – OCMW add to the administrative burden experienced by health professionals and health services. This administrative burden has to be linked with the communication issue previously discussed: indeed, as the requirements are changing over time, health professionals should be continuously informed about the modifications. But the lack of information concurs to the administrative burden.



« Au niveau de la procédure, pour chaque prestation médicale, on doit faire une attestation, un certificat d'aide médicale urgente à renvoyer au CPAS – OCMW, si le CPAS – OCMW n'a pas ce certificat et la facture, ils ne remboursent pas. Donc il ne faut pas seulement que la carte d'aide médicale soit accordée et prolongée tous les trois mois, en plus chaque consultation doit être prouvée par un certificat d'aide médicale urgente. »

Quote retrieved from a focus group

« On demande beaucoup plus de justifications qu'avant et, au niveau des services administratifs des hôpitaux, ça demande beaucoup de procédures. »

Quote retrieved from a focus group

The length of the procedures is the fourth component of the complexity. UM and HCP agree that the length of the procedures is a problem for both for CPAS – OCMW, UM and health care providers. This also increases the uncertainty about the outcomes of the procedure for both CPAS – OCMW and health care professionals. For the UM, this uncertainty also contributes to a poor mental health through increasing stress and anxiety. The length of the procedures concerns the authorisation of UMA but also the delays in paying the medical fees of the HCP. Again, it may discourage solo HCP to work with UM.

« Un autre problème, c'est la longueur des procédures aussi, les assistantes sociales doivent attendre les réponses et y en a peu qui aboutissent. »

Quote retrieved from a focus group

« Le CPAS – OCMW paie après […] mois. Après, on attend un courrier et il ne faut pas être pressé de recevoir son argent parce que les payements ne se font pas immédiatement. »

Quote retrieved from a focus group

The fifth aspect of complexity is reported by health professionals: **the existence of different requirements according to each specific CPAS – OCMW**. Indeed, for health professionals working across different municipalities, they must comply with different rules and procedures, although the final objective remains the same: providing health care to UM. Consequently, health professionals have to develop an extensive field knowledge of the practices of all CPAS – OCMW.

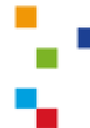
« Au niveau social, en fonction du CPAS – OCMW à force de travailler sur le terrain on sait très bien qui est ouvert et qui ne l'est pas dans les différents CPAS – OCMW. Or, à la base, la législation est la même pour tous les CPAS – OCMW. Pour moi c'est pareil, je sais qu'à [X], ce sera plus difficile alors que [X], j'aurai plus de chances etc. [X] très strict aussi, et tout ça pour la même situation hein, le même patient. »

Quote retrieved from a focus group

A final component of the complexity is the different procedure to access specialty care when compared to Belgian patients. Indeed, accessing specialty care is impeded by the existence of a **gatekeeping system**: if an UM needs specialty care, she/he should first go to the general practitioner before introducing an application to the CPAS – OCMW. Then the UM has to wait for the decision of the CPAS – OCMW. For health professionals, this requires the adaptation of the health care plan as this gatekeeping system may delay the overall treatment. HCP sometimes bypass the gatekeeping by calling in for personal favour, depending of the situation.

« Quand on a un rendez-vous, on doit aller chercher un réquisitoire à la maison médicale pour aller à [X], Si j'ai rendez-vous à [X], je peux pas y aller comme ça, je dois aller chercher un réquisitoire [au CPAS – OCMW] et avec le réquisitoire je vais à [X] et je donne mon identité. »

Quote retrieved from an interview with an undocumented migrant



The complexity of procedures in Belgium was also pointed out as a major barrier to health care in previous studies and reports (see e.g. [31, 49, 50]). In particular, this complexity of procedures increases the risk of (further) exclusion of persons with low literacy skills or low knowledge of national languages. It also concentrates the population of UM on large structures such as hospitals and/ or in urban centres because of the higher availability of strong and organised administrative structures to cope with the complexity. Moreover, the overall complexity of the UMA procedure will lead to an increased risk of discretionary decisions.

5.4.1.4 Discretionary decisions

Discretionary decisions occur at all levels of the health care system. UM experienced lots of **variation in the quality, the availability or the accessibility of the services provided, depending on the professional, from social or health services, and the day**. These variations in quality, accessibility or availability are also reported by the health professionals in relation to other health professionals, to health care managers and to social services. These discretionary decisions are likely to lead, in some circumstances, to uncertainty or unequal treatment.

> *« Ça arrive souvent au relais santé avec les personnes qui dorment dans les abris de nuits et on voit qu'en fonction d'un assistant ou l'autre le traitement de la demande n'est pas le même. C'est arbitraire ».*
>
> Quote retrieved from a focus group

> *« Chaque CPAS – OCMW fait vraiment à sa sauce. Y a une interprétation, donc deux solutions différentes à un même problème et tout le monde n'est pas sur la même longueur d'onde. Avec tel CPAS – OCMW, il y aura un accord, avec tel autre CPAS – OCMW il n'en aura pas. »*
>
> Quote retrieved from a focus group

> *« Il y a vraiment différentes interprétations, même au sein d'un même hôpital. Or effectivement, c'est au médecin de décider si ça rentre dans l'AMU. Et comme il y a une mauvaise information, une mauvaise connaissance de la notion, qui est ambiguë dans ses termes mêmes, cela peut mener à des traitements différents entre différents médecins de la même institution. »*
>
> Quote retrieved from a focus group

Discretionary decisions limit the range of services available to UM but the most severe consequence of discretionary decisions is the **refusal of care**. Denying access to health care, restricting the availability of a service or delivering health care of low quality because of the undocumented status of the UM are violations of the Law of 2007 against discrimination[ss]. Indeed, the situations in which UM report being refused, for example, by a pharmacy because the pharmacy declares not to work with the CPAS – OCMW, are absolutely not acceptable. Health professionals who refuse to care for UM should at least refer them to colleagues or appropriate services in order to ensure the access to health care for these UM.

> *«J'étais allé voir à [X], un spécialiste, un psychologue. On a eu un rendez-vous, il a fait un entretien et après il m'a dit : « je vais voir avec les médecins ce qu'on peut faire et on va vous appeler pour vous proposer des rendez-vous pour soigner l'enfant ». Mais après, il m'a appelé et il m'a dit que c'est pas possible de faire toutes ces analyses parce que vous êtes en situation sans papiers, vous avez pas mutuelle. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« Je vais à la Pharmacie [X], c'est les seuls qui ont accepté. »*
>
> Quote retrieved from an interview with an undocumented migrant

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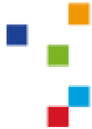
[ss] Loi du 20 mai 2007 tendant à lutter contre certaines formes de discrimination / Wet van 10 Mei 2007 ter bestrijding van bepaalde vormen van discriminatie.



« Ze zeiden dat het nodig was dat ik een operatie deed om de nodulen in mijn schildklier weg te doen, maar na negatieve beslissing asielaanvraag was dat plots niet meer zo dringend om operatie te doen, en dan uiteindelijk zelfs niet meer nodig. »

Quote retrieved from an interview with an undocumented migrant

Inside CPAS – OCMW, discretionary decisions could take form of **providing misinformation**, **holding back information**, or **showing inertia**. The absence of justification of the negative decisions increases the incomprehension for the UM and reinforces the discretionary dimension of the UMA. All these discretionary practices are condemned by the law of 1965 on social aid.

« J'ai mal aussi à la poitrine mais au CPAS – OCMW y a des maladies et on te dit qu'on les prend pas en charge. [On vous explique pourquoi?] Non on dit c'est comme ça, des fois on t'écoute même pas. »

Quote retrieved from an interview with an undocumented migrant

« J'ai dû retourner plusieurs fois et ils me renvoyaient ou me laissaient attendre toute la journée jusqu'à ce qu'ils ferment. »

Quote retrieved from an interview with an undocumented migrant

Moreover, in some circumstances, the social assistants rely on the police to support discretionary decisions. Indeed some UM report that in some municipalities' social workers ask the **police** to verify the address of residence. The HCP state that this practice should be condemned, especially as this is clearly forbidden by law. However, these statements need to be examined carefully, since they also may have been used as a threat towards UM who are unwilling to share their address with the CPAS – OCMW. This latter is also punishable by the Law of 1965, condemning members of a CPAS – OCMW relying on authority or other form of power.

« Finalement, j'ai vu une assistante qui a dit qu'ils devaient faire une contrôle à domicile avec la police. »

Quote retrieved from an interview with an undocumented migrant

Discretionary practices vary from one CPAS – OCMW to another. Indeed, UM also report **different treatments depending on the CPAS – OCMW**. For example, a young man who did not receive UMA in one municipality moved to another city where he was entirely covered for all his health care needs. This is also reported by health professionals.

« A [X], à la commune, ils n'ont pas accepté de m'aider pour l'insuline. Je suis partie à [Y], (…) j'ai expliqué mon problème et ils m'ont amené au CPAS – OCMW de [Y], pour avoir l'aide médicale urgente au relais santé, et après ils ont commencé à me donner l'insuline. »

Quote retrieved from an interview with an undocumented migrant

« We werken wel met kleinere OCMW's en soms is er onvoldoende kennis van de wet en is de maatschappelijk werker onvoldoende op de hoogte en vaak bang voor financiële repercussie voor het afleveren van een kaart. Ze vrezen misbruik en hierdoor perken ze het afgeven van medische kaarten in tot 1 dag of een paar dagen of voorafgaand te vragen aan het ziekenhuis wat de behandeling is. Dat mag in principe niet, maar in de praktijk gebeurt het wel. »

Quote retrieved from a focus group

Although the **MediPrima system** aims at simplifying the procedures and decreasing the discretionary power of social assistants, UM relate negative experience in a CPAS – OCMW using MediPrima. Also at the side of the health professionals, some pitfalls regarding MediPrima are signalled, as they might refrain UM from accessing health when not applied correctly.

« Mais, maintenant avec MedPprima, c'est difficile. Là, on a eu un rendez-vous mercredi, on est allé au CPAS – OCMW ce matin, on a demandé à l'assistante sociale pour dire qu'on a rendez-vous mercredi. Mais je ne sais pas, si l'assistante sociale ne donne pas le réquisitoire, moi je vais devoir payer de ma poche. Ce matin, on ne me l'a pas donné le réquisitoire on m'a dit : « attends, je dois aller chez l'échevin », puis l'échevin, il fait un comité, je sais pas, c'est des problèmes. Mais il ne sait pas dire quand on l'aura, il a dit demain je vais parler avec mon chef tatata. »

Quote retrieved from an interview with an undocumented migrant

« Met Mediprima is de samenwerking en snelheid van informatie beter. Je hebt sneller zicht op de informatie van de patiënt. Ook in avond en weekenduren kan je systeem consulteren, dat heeft allemaal zijn waarde. Maar door foute interpretatie zijn er wel nieuwe gevaren. Zo moet het OCMW type zorgen toewijzen aan patiënt. Dat is zeer vergaand (..)[X] heeft zijn beleid, maar kleine OCMW's of andere steden zeggen dat enkel zorg kan genoten worden in een ziekenhuis waarmee ze een akkoord hebben en dat is echt een gevaar en beperkt ook de mogelijkheid van het vrij verplaatsen op het grondgebied. En dat zou niet mogen, het zou op feitelijkheid moeten gebaseerd zijn en als een arts beoordeelt dat het om DMH gaat, dan kan daar niet over gediscussieerd worden. De hulpkas is er nu gekomen, die medische adviseurs heeft, en de opdracht bestaat eruit attesten in ziekenhuizen en bij huisartsen na te kijken. Maar door foute interpretatie wordt zorgtoegankelijkheid ingeperkt. Ik vind dat een beetje onofficieel gegijzeld worden in een stad of verblijfregio. »

Quote retrieved from a focus group

At exo level, UM and HCP report situations where there are **contradictions between the procedure followed by the CPAS – OCMW and the practices of health professionals**. Again, the absence of justification of the decisions is likely to increase the feeling that decisions are made on a discretionary basis.

« Le médecin avait prescrit 4 séances par semaines, il a fait tous les examens possibles même une ponction du cœur, mais le CPAS – OCMW a dit: 'deux'. Le médecin était tellement furieux. »

Quote retrieved from an interview with an undocumented migrant

Health professionals and UM report situations where the CPAS – OCMW allow the required treatment, but only a modified one: for example, several persons report cases in which the number of glycaemia checks is decreased from 4 to 2 checks a day by the CPAS – OCMW. In other situations, UM are allowed to consult a specialist, but additional exams are not covered by CPAS – OCMW.

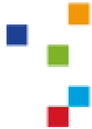
« En voor de suiker; tweemaal is beter dan niets [lacht], maar voor een echte diabeet is een goede behandeling vier maal op dag, met een schema. Het is normaal voor iedereen, waarom? Zijn migranten dan maar halve mensen? »

Quote retrieved from a focus group

When the situation of the UM becomes a medical emergency, the CPAS – OCMW accepts to cover for the fees. Some health professionals also report that an UM in a critic condition is more likely to be accepted for UMA than a patient in a stable condition. Some health professionals even question this attitude of the CPAS – OCMW saying that they may not treat the UM so they will have a more severe health problem to ensure the health care coverage. This is clearly a situation in which the CPAS – OCMW almost press the HCP to commit a professional fault.

« J'avais du cataracte et le médecin voulait m'opérer mais le CPAS – OCMW disait non. Puis je me suis heurté en sortant de l'hôpital, et puis ils ont décidé de me donner du transport pour aller à l'hôpital et de payer pour mon opération, je voyais très mal. »

Quote retrieved from an interview with an undocumented migrant



« On a ça avec les enfants asthmatiques. Ils [le CPAS – OCMW] considèrent que c'est une maladie chronique et ne prennent en charge que quand il y a des crises. Donc, quelque part, on doit mal soigner nos patients pour qu'ils puissent être pris en charge. »

Quote retrieved from a focus group

To counterbalance such discretionary decisions, some health professionals contact the CPAS – OCMW to protest against the decision taken by them, but other health professionals accept the decision with some fatalism, saying that the CPAS – OCMW has made the decision.

« Soit le médecin prend son téléphone et crie un bon coup mais je ne suis même pas sûre que ce soit efficace… »

Quote retrieved from a focus group

Discretionary decisions could be potential causes of **tensions and conflicts between health professionals and CPAS – OCMW**, but also between UM and CPAS – OCMW.

« Je téléphone au médecin conseil du CPAS – OCMW et je me fâche. Je contacterais le médecin conseil et je lui dirais qu'il y a un problème. »

Quote retrieved from a focus group

Health professionals also question the competences of the social assistants of the CPAS – OCMW when assessing the relevance of an application of urgent medical aid and the nature/extent of the treatment. Some health professionals report their disapproval of CPAS – OCMW modifying the treatment, irrespective of the medical doctor's prescription. In some cases, they report that social assistants assess the relevance of medical prescriptions and/or treatments without consulting the medical doctor attached to the CPAS – OCMW. This latter is particularly problematic and, again, may be punishable as the social assistant is not allowed to access confidential patient information.

« Un autre souci que j'ai, c'est à propos du respect du secret médical. On doit remplir la fiche et les AS les lisent et non les médecins conseils comme prévu. Pour moi ça, ça ne va pas du tout, on met des choses très sensibles, ça devrait rester dans le circuit médical. Ça ne devrait pas changer la façon dont l'AS [l'assistante sociale] intervient et accompagne les gens. »

Quote retrieved from a focus group

Besides the modifications of the treatments – in a broad sense – by the social assistants, health professionals also question the **contradictions between the practices of the CPAS – OCMW and the guidelines in public health**. Some CPAS – OCMW prefer referring UM patients to inpatient services in hospitals rather than referring UM patients to primary care services or GPs for all health care needs, even for health problems that should be cared for in primary care.

« On se rend compte que le système administratif va à contre sens du système de santé publique où on sait que la prise en charge en première ligne permettrait de diminuer les coûts. »

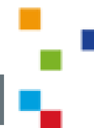
Quote retrieved from a focus group

Some UM report receiving **different treatments** at social or health services, when being accompanied by a professional or volunteer from a NGO. In these situations, the UM perceive to receive a better treatment than if they would go alone to these services.

« Ce n'est que quand je suis allé avec X de Medimmigrant qu'ils étaient gentils et qu'ils expliquaient la situation tout de suite. C'est bizarre, non? (…) Comment je pourrais faire sans Medimmigrant ? vraiment… [pleure] »

Quote retrieved from an interview with an undocumented migrant

However, health professionals report that UM receive a different treatment when being referred by a NGO.



« Moi, je me suis rendu compte, j'ai suivi les consultations Médecins du Monde du CASO pour ceux qui sont exclus de tout. Et donc on faisait aussi une enquête sociale et on demandait l'AMU quand on estimait que c'était possible. On avait un taux d'acceptation très, très bas. Puis, j'ai arrêté ça et je suis allé travailler à la maison médicale [X]. Et pour le même patient, ou le même type de patients, Dr [Y] de chez Médecins du monde : refus. Dr [Y] Maison médicale [X] : accepté. »

Quote retrieved from a focus group

5.4.2 Four areas of potential improvements and solutions

5.4.2.1 Clear definition of urgent medical aid

Firstly, as for coverage of health care and necessary treatment, in all focus groups, health care providers emphasize that **more transparency and coherence** is needed about what is covered by UMA and what is not. Some suggest having a uniform and sensible list of covered care which would avoid discrepancy in coverage by different CPAS – OCMW. Although all of them are in favour of transparency, some health care providers worry that harmonisation in UMA coverage would lead to downsizing the scope of treatment and care offered.

« Je pense qu'un terme plus comme « soins médicaux essentiels » serait plus approprié. Je prends l'exemple de l'amblyopie chez l'enfant, si on sait dépister une perte d'acuité chez un jeune enfant, le fait de ne pas être soigné, ça va handicaper toute sa vie. Ce n'est pas qu'une question de timing où la vie est en danger un moment donné, on n'est pas en train de faire un infarctus mais ce sont des soins essentiels pourtant. Il faudrait que ce soit clairement pris en charge, comme la vaccination. Des soins essentiels quand on peut prouver que ça va handicaper fortement la santé future et le développement d'un enfant. Je pense que c'est important. »

Quote retrieved from a focus group

« Ik ben anderzijds een beetje bang dat – da's voor onze persoonlijke situatie – dat men het gaat harmoniseren. Want een gemiddelde harmonisatie zou dan eventueel kunnen nadelig zijn. Omdat toevallig het OCMW van [X] eigenlijk op een - in onze ogen – zeer correcte manier handelt, terwijl het aangrenzende OCMW bijvoorbeeld hier veel moeilijker rond doet". »

Quote retrieved from a focus group

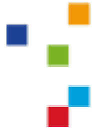
« Il ne faut pas non plus rentrer dans le piège du gouvernement qui voudrait définir de façon précise ce qui rentre dans le cadre de l'aide médicale urgente ou pas, parce que c'est un des projets du gouvernement actuel. Ne faut pas tomber dans ce piège là même si voilà y a des choses, dont le traitement orthodontique, que même la population belge ne sait pas se payer ! C'est dangereux. C'est réducteur. Y aura toujours bien l'un ou l'autre acte, l'une ou l'autre pathologie qui ne sera pas dedans. C'est ingérable. Déontologiquement ce n'est pas acceptable. »

Quote retrieved from a focus group

Secondly, both undocumented migrants and health care providers are unanimous about the **need of opening up to an inclusive care package in specific situations** of chronic diseases, pregnancy and newborn health and most of them also state that this is necessary for children.

« On a ça avec les enfants asthmatiques. Ils considèrent que c'est une maladie chronique et ne prennent en charge que quand il y a des crises. Donc quelque part on doit mal soigner nos patients pour qu'ils puissent être pris en charge. On compense nous, en étant à la limite de la légalité parfois pour avoir des soins continus et corrects mais on devrait laisser les gens malades jusqu'à la crise sachant que la crise va arriver en se disant ben on devra attendre la crise pour pouvoir les prendre en charge. Crise qui coutera plus cher que s'ils étaient soignés pour qu'on l'évite. »

Quote retrieved from a focus group



« Pour le HIV, ils le donnent à l'ARC (AIDS Reference Centre). Chaque deux mois, je dois y aller pour une prise de sang, et pour le bébé à l'accouchement, ils l'ont donné un sirop et puis du lait en poudre et il n'a pas le HIV, ils vont faire pareil maintenant quand le deuxième sera né. Enfin, j'espère maintenant que je suis sans papiers, je ne sais pas si l'OCMW va vouloir le payer, ou qui d'autre. Mais c'est nécessaire, sinon… comment?... »

Quote retrieved from an interview with an undocumented migrant

« Eersteleeftijdsmelk: Wat we eigenlijk wel kunnen doen, maar dat mogen we eigenlijk niet doen, dat we stalen kunnen krijgen, maar dat is ook heel hard geminderd. Dus dat is eigenlijk wel moeilijk. Sommige collega's hebben al zelf betaald, maar dat vind ik nu toch ook niet de oplossing. »

Quote retrieved from a focus group

« Medicatie voor kinderen zou toch op de lijst moeten staan: jezelf kan je wegcijferen maar je kinderen niet".

Quote retrieved from an interview with an undocumented migrant

« Aan Maggie De Block zou ik wil zeggen: jij bent toch ook moeder, kan je je dan ook als moeder gedragen en een kind de kans geven om zich verder te ontwikkelen? Zijn ziekte kan niet behandeld worden in Tsjetsjenië, hier wel, maar sommige dokters weigeren het papier van dringende medische hulp te tekenen. Zeker voor orthopedische hulpmiddelen. Het is een slimme jongen, hij wil leven, zich ontplooien, ondanks zijn handicap". »

Quote retrieved from an interview with an undocumented migrant

Thirdly, the UM and health care providers also agree to **include social determinants of health** in the provided services, such as giving food, since this is just a prerequisite to stay alive, to not even develop more health problems and to be able to adhere to the prescribed treatment, which is paramount to ensure effectiveness of the prescribed treatments.

« Avec l'AMU, on peut être soigné mais on peut mourir de faim à côté. »

Quote retrieved from a focus group

Health care providers also question whether it is not possible to have **other types of financial guarantees** that cover the costs of treatment. Some suggest to have payments by capitation; others suggest to replace UMA by mutuality ensuring an inclusive coverage of all RIZIV/INAMI nomenclature, since this would have multiple benefices for both migrants and health care providers: there would be more equity in care, and it would ease the required knowledge about procedures for health care providers.

« Il faudrait un système comme la couverture mutuelle où seul le prestataire de soins juge en âme et conscience ce dont le patient a besoin ou pas. Cet aval a priori est difficile à gérer. »

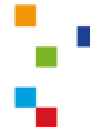
Quote retrieved from a focus group

« Alle prestaties die een nomenclatuurnummer hebben, dat is het meest eenvoudige en begrijpbaar voor artsen ook". »

Quote retrieved from a focus group

« Ce serait un statut d'attente, transitoire, accordé automatiquement et sans limitation de temps. Avec les règles de l'INAMI pour ce qui est des soins. »

Quote retrieved from a focus group



As a solution for the problems of covering the additional (not refunded) costs, undocumented migrants suggest that if they would be authorised to work legally, they would be able to pay for the care that is now not covered by UMA.

« Mais pour moi, je voudrais déjà avoir la chance de travailler, comme ça je participerais à l'impôt, et je pourrais m'acheter les médicaments. Je n'ai pas les médicaments, ça peut s'aggraver. Il faut nous donner une chance de faire quelque chose. »

Quote retrieved from an interview with an undocumented migrant

Finally, some health care providers firmly state that **health is a human right**, and the fact that a person resides on Belgian territory should ensure their access to health care as well as the provision of the same quality of care as would be given to nationals (or residents with legal documents). European coordination and **universal health coverage** could help to finance this assured access.

« Ik denk dat… sowieso een specifiek statuut creëren voor dringende medische hulp voor een aparte groep,- want het is sowieso een bevolkingsgroep die al moeilijk toegang heeft tot zorg dus is er geen extra drempel nodig – dat het slecht is voor de mensen zelf als voor de openbare gezondheidzorg. Het bemoeilijkt het opvolgen van chronische aandoeningen, het bemoeilijkt preventie. Dus, vanuit puur medisch perspectief bekeken: als de mensen toch op ons grondgebied verblijven, dat ze dan toegang hebben tot de normale reguliere zorg zoals andere mensen die hier papieren hebben. »

Quote retrieved from a focus group

« Il y a une mauvaise information et il n'y a pas de coordination au niveau européen non plus. Donc il faudrait une couverture universelle européenne pour les illégaux. »

Quote retrieved from a focus group

In order **to avoid further confusion** about what urgent medical aid entails, several **corrective actions** were suggested. Health care providers emphasise that as long as the current definition is upheld, it is necessary to inform all stakeholders about the error of interpreting "urgent medical aid" as "emergency health care", since this is not what is stipulated in the law.

« Het is belangrijk om vertaling van de wetgeving mee te geven: er is een verschil tussen hoogdringende geneeskunde en dringende medische zorg, die is veel breder en gaat naar zowel preventieve tussenkomsten als acute hoogdringende zorg. Het preventieve, het voorkomen van ernstige duurdere zorg is heel belangrijk daarin". »

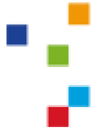
Quote retrieved from a focus group

Moreover, several health care providers suggest replacing the word "urgent" in the definition by the word "necessary"[tt], as well as the word "medical" by "health", since these reflect better what is stipulated in the law, which would lead to the term **"Necessary Health Aid"** instead of "Urgent Medical Aid" .

« Beter 'noodzakelijk'; Het zou beter noodzakelijke hulp zijn geweest, met ook preventieve acties, inentingen enzovoort. In het rondschrijven van Peeters-Colla viel dat er allemaal onder. Naderhand is dat totaal uitgehold geworden, hé, naar hoogdringende zorg". »

Quote retrieved from a focus group

[tt] "Noodzakelijk"" in Dutch or "Essentiel" in French.



« Pour moi, tout le monde a droit à tout. À partir qu'on estime que telle population qui rentre dans tels critères y a droit alors ils ont droit à tout, on ne va pas chercher quel CPAS – OCMW, quel machin, quelle commune… Il faudrait une aide médicale universelle et non plus urgente et basta. »

Quote retrieved from a focus group

5.4.2.2 Adequate and accurate information and communication

Both healthcare providers, managers and undocumented migrants offer ideas and suggestions to improve the information sharing and communication bottlenecks.

First, regarding information, knowledge and literacy about the UMA procedure, several respondents – both migrants and professionals – refer to necessary improvements that could be made in the law, such as a **more stable legal framework**, as a leverage for better implementation.

« If the law could be steady, it would be better, now it changes all the time, doctors and social assistants can't follow. »

Quote retrieved from an interview with an undocumented migrant

Moreover, some health care providers highlight the **need for training** for professionals about UMA procedures, intercultural competence and 'global health', both in their mainstream curricula to become a healthcare provider as once they are already working in their profession. Health practitioners also suggest training in specific themes to enhance the coverage of care and treatment such as for malaria, sickle cell disease, and various tropical diseases.

« In een grote organisatie zoals een ziekenhuis is het mogelijk om artsen daarover proactief te informeren, iets wat veel moeilijker is in eerste lijn. Er wordt geprobeerd veel meer door te communiceren en worden initiatieven genomen om vorming te geven over toegankelijkheid in de eerste lijn vanuit mutualiteiten, maar die zaken worden ook opgenomen door het OCMW. Dus je merkt wel meer vormingsinitiatieven omdat [X] die initiatieven wil nemen. Dat is zeer vrijblijvend. In [Y] en [Z] is eerder stagnatie of achteruitgang […] wat eigenlijk hun toegankelijkheid had moeten zijn, wordt een barrière extra. »

Quote retrieved from a focus group

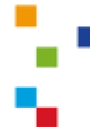
« C'est un sujet qui va continuer à exploser dans les années à venir, ce serait mettre en place dans tout ce qui est métiers hospitaliers, de l'assistant social, à un éducateur, un médecin, une infirmière, durant leur cursus scolaire, une formation sur ce qu'est l'AMU [Aide Médicale Urgente]. Parce qu'ils se retrouvent en stage et du jour au lendemain ça évolue. Si on en a déjà un peu conscience pendant les études, si on est sensibilisé c'est bien. Au niveau médical et au niveau des acteurs psycho-sociaux, psychologues, infirmières, etc. »

Quote retrieved from a focus group

Furthermore, they have **practical suggestions to go about currently occurring UMA-related problems** as for example not knowing which medication is being covered by UMA and not.

« We moeten artsen leren om op stofnaam voor te schrijven in plaats van op merken. »

Quote retrieved from a focus group



In addition, regarding language barriers, several healthcare providers consider **translation** and **interpretation** as key elements to ensure the quality of care and to ensure patient rights. Besides, Belgium already offers high-quality intercultural mediation in various health care settings.[51] Expanding intercultural mediation in outpatient settings may help UM and health care providers.[25, 26]

> *« Het is belangrijk om met taalbijstand te werken. Heel veel zaken van informatie die niet kloppen liggen aan de oorsprong dat de patiënt het gevoel heeft dat info gedeeld kan worden met bijvoorbeeld gerechtelijke instanties. Mensen zijn ook onvoldoende geïnformeerd van wat onze rol is en ons belang is en als je dat met heel beperkte communicatie doet (...) heel belangrijk dat zeker het introductiegesprek in de herkomsttaal kan verlopen. »*
>
> Quote retrieved from a focus group

> *« Oui y a le centre d'appels unifiés de Londres et ils ont 500 langues disponibles. C'est le système d'appels 999 spécifique pour les soins de santé. Je ne sais pas ce que ça coute, mais en tout cas, on peut vous répondre dans votre langue quasiment immédiatement quand vous appelez au secours. Nous à l'hôpital, on a répertorié les langues de tous les travailleurs et donc on parle entre 45 et 50 langues dans l'hôpital, chinois, japonais, langues slaves, africaines, européennes. Ça c'est une force. Ce sont des petits trucs mais exploiter les forces disponibles sur le terrain. »*
>
> Quote retrieved from a focus group

Finally, regarding **communication skills**, undocumented migrants stress that these skills should be evaluated as a vital competence of social workers in CPAS – OCMW, and suggest social workers should receive **specific training** in giving "bad news", in intercultural communication and in empathic conversations on all sorts of sensitive issues, including sexual and reproductive health. This is consistent with previous recommendations in Belgium.[25, 26, 52-54].

> *« Donner des informations comme il faut, parler correctement les assistantes, sans brusquer les gens, sans te dire que tu es zéro. »*
>
> Quote retrieved from an interview with an undocumented migrant

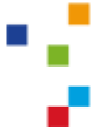
> *« Firstly train to work in an OCMW, learn people to communicate better to everybody not only to UM, even if they cannot give positive news, they should know how to bring negative news, no panic, explain what you have, consequences. »*
>
> Quote retrieved from an interview with an undocumented migrant

5.4.2.3 Simplification of procedures

To reduce the complexity of the procedure, **having a "medical card"** instead of "réquisitoire" covering a single act is put forward as an effective solution. It decreases the need of additional visits to the CPAS – OCMW, it simplifies the access to specialty care or to medications. This is supported by the 2008 report of Casman.[55]

> *[« Et quand on a la carté santé?] Alors je ne dois pas faire tous ces tours-là, j'ai le carnet de santé et je vais chez mon médecin. Il prend mon carnet, il fait des papiers pour passer des examens à l'hôpital par exemple. Alors je peux aller à l'hôpital et prendre un rendez-vous qui doit tomber dans la période où la carte santé est encore bonne. Alors je peux me présenter ce jour-là directement à l'hôpital. Même pour les médicaments alors je prends seulement le papier d'ordonnance et mon carnet santé et je peux avoir mes médicaments c'est automatique je dois pas repasser par le CPAS – OCMW. »*
>
> Quote retrieved from an interview with an undocumented migrant

When they benefit from the medical card, UM and health professionals suggest that the **(automatic) extension of the validity of the UMA coverage** would help them to a large extent. Allowing an automatic extension of the UMA coverage prevents that people need to take multiple demarches to receive health care coverage and also largely reduces



feelings of uncertainty. It may also decrease the burden related to the procedures, especially the social enquiry, for the social workers in the CPAS – OCMW. For health professionals, some health care situations have a clearly defined duration (e.g., pregnancy) and the coverage of UMA should be determined according to this temporality.

« Y a des CPAS – OCMW qui font repasser la personne tous les mois alors que, bon, quand même, une grossesse, c'est pas nouveau que ça dure 9 mois. »

Quote retrieved from a focus group

Moreover, **rendering UMA for the entire household**, instead of only for one family/household member, is also reported as a way to decrease the procedural complexity. Indeed, in some municipalities, each member of the household is considered separately, multiplying the number of social surveys for the CPAS – OCMW and for the UM concerned.

« Sinon pour les autres membres de la famille je dois passer chez le médecin pour avoir l'attestation et pour un mois chez l'assistante et pour deux mois au CPAS – OCMW, je dois faire les trajets alors que je suis enceinte avec le gros ventre. »

Quote retrieved from an interview with an undocumented migrant

Giving access to UMA for the entire household may also support preventive care, and can prevent unnecessary or even negatively impacting delays in accessing health care in case of acute health problems. Limiting the extent and the number of social surveys is also suggested as a solution to decrease the complexity of the procedures.

The concept of **"anticipative UMA"** is also suggested as a solution to reduce complexity. In other words, the procedure should allow introducing an application to UMA before being ill, that is without fulfilling the condition of "health care needs" stated in the Royal Decree of 1996. This solution has a preventive effect and is likely to decrease the number of administrative tasks when the UM presents at the health service.

« A ce moment-là je n'avais pas de problèmes de santé. J'ai dit oui j'ai besoin d'une carte médicale si jamais j'ai la grippe ou comme ça. Si jamais ça arrivait. Mais à ce moment-là, c'était y a trois ou quatre ans. Et un an après, la main il y a quelque chose qui n'allait pas. Quand je dormais, je sentais plus ma main »

Quote retrieved from an interview with an undocumented migrant

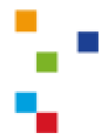
« -Ook worden alle mensen die een maand op voorhand gepland staan door cel SOFIA preventief gecontacteerd om hen te waarschuwen voor betaalzorg, om taalbijstand te organiseren en te vermijden dat de patiënt zich aanbiedt met nood aan zorg en dan pas het probleem aangekaart wordt. We willen vooral een integrale benadering en dat voor alle papieren."

Quote retrieved from a focus group

« Bij mensen die geen medische kaart of mutualiteit hebben gaan wij bij eerste huisbezoek van pasgeborenen contact met OCMW maken en hen doorsturen want iedereen is verschillend- we sluizen hen ook door naar het wijkgezondheidscentrum – zo hebben ze een poot om op te staan, als er iets is weten ze waar naartoe (…), we maken hen warm en we wachten niet tot het probleem er is, maar we regelen voor het kindje alles op voorhand. »

Quote retrieved from a focus group

UM also report that the CPAS – OCMW should support homeless UM by providing **a "convenience" address**, since giving an official address is one of their main difficulties. This practice is already used by some CPAS – OCMW when caring for Belgian homeless people. This "convenience" address could be either the address of the CPAS – OCMW, either the



address of a supporting organisation, such as the SAMU Social[uu] or a church.

> *« Het zou mogelijk moeten zijn om medische kaart te krijgen zonder adres te verifiëren, zeker voor kinderen, ik zou echt bang zijn als we geen medische kaart zouden hebben want kinderen komen vanalles tegen. Sommige mensen helpen je wel (bijvoorbeeld vanuit kerk) maar voor adres niet, dus als je geen adres hebt, dan is het heel erg moeilijk. »*
>
> Quote retrieved from an interview with an undocumented migrant

> *« Ne pas demander des adresses fixes, surtout si tu habites chez quelqu'un d'autre, trouver d'autres manières pour vérifier où tu habites, est-ce même nécessaire de savoir ? »*
>
> Quote retrieved from an interview with an undocumented migrant

> *«Ja, bijvoorbeeld sommige patiënten laten zich vergezellen door een vriend hé, waarbij ze logeren in België. Die vriend durft dan niet zeggen dat er een patiënt bij hem inwoont omdat hij ook van het OCMW afhangt en dus heum verklaren we hem dan dakloos, die patiënt, terwijl wij weten dat hij bij een vriend woont, dus heum. Allé ja…»*
>
> Quote retrieved from a focus group

Some health professionals suggest that the **MediPrima system** is a good way to solve the problems related to the complexity of the procedure, although this positive evaluation of MediPrima is not supported by all health professionals.

> *« MediPrima werkt prima! Ja, dat werkt heel goed. Bij ons werkt dat echt (gelach omwille van verschillende mening tussen [X] en [X]) Ik denk dat het juist hetzelfde is, zoals je nu elektronische berichten naar de mutualiteit uitstuurt, en antwoord krijgt. Ik denk dat het juist hetzelfde is, aan de balie; klik, en wij krijgen direct bericht binnen, tot dan, … Voor de patiënten die daar geweest zijn. Allé ja, het is een aanrader. »*
>
> Quote retrieved from a focus group

On the one hand, health professionals argue that MediPrima simplifies the administrative aspects of the UMA procedures. On the other hand, health professionals report that MediPrima reduces the extent and length of the UMA coverage, adds to the complexity of the procedure, limits the therapeutic options and restricts the choice of patients of their health care professionals. The limitation of therapeutic options means that the HCP will have to choose the treatments and medications in a list, restricting the possibility of providing individualised, flexible and personal care. Besides, the Law of 2002 related to the patient rights states that:

> *« Le patient a droit au libre choix du praticien professionnel et il a le droit de modifier son choix, sauf limites imposées dans ces deux cas en vertu de la loi. »*[vv]
>
> Loi du 22 août 2002 relative aux droits du patient. Chapitre III Droits du patient. Art.6.

> *« De patiënt heeft recht op vrije keuze van de beroepsbeoefenaar en recht op wijziging van deze keuze behoudens, in beide gevallen, beperkingen opgelegd krachtens de wet. »*
>
> Wet van 22 augustus 2002 betreffende de rechten van de patiënt. Hoofdstuk III Rechten van de patiënt. Art.6.

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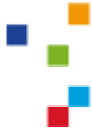
uu The SAMU Social is a non-profit organisation aiming at providing asylum and social support to homeless UM and homeless persons in Brussels. http://samusocial.be/

vv Restrictions concern, among others, emergency situations and situations of juridical incapacity.



Indeed, UM and HCP report that choosing his/her health professional is important for the quality of the relationship between the UM and the HCP. In some municipalities, this is not yet the case: the CPAS – OCMW either choose the HCP for the UM, either provides a list of HCP in which the UM may choose his/her HCP. The latter is preferable as the UM may not be aware of the available health professionals. By giving a list and providing information about health services, the CPAS – OCMW ensures access to adequate health services for the UM. Another concern is to prevent the development of "health care ghetto" by orienting preferably UM to some health services, concentrating the burden of the UMA procedures on a small number of health professionals and health services.

Finally, some HCP express their concerns about the effectiveness of MediPrima when it comes to discretionary issues.

« L'intention est louable et intéressante mais la mise en pratique est extrêmement compliquée. Cela dépend de la bonne volonté des opérateurs tels que les CPAS – OCMW, dans chaque CPAS – OCMW, ça dépend aussi de la bonne volonté, de la connaissance, de la compétence de chacun des intervenants. Y a une part d'arbitraire dans l'application du dispositif qui en soi est bien pensé, si il était bien appliqué. Il y a un décalage entre la théorie et la pratique. »

Quote retrieved from a focus group.

But, although not all health professionals support the MediPrima system, most of them stress the need for a simplified and standard procedure to decrease the overall complexity of the procedure.

Health professionals also argue that a **better coordination of the procedure between different health services** is likely to improve the continuity of care for patients, and may avoid unnecessary administrative procedures.

« Wij hebben dus een geïnformatiseerd sociaal dossier en we proberen zo veel mogelijk gegevens bij te houden zodanig dat we als patiënten terug komen, en bij chronische patiënten is dat toch wel gemakkelijk, om te kunnen zien en te kunnen opvolgen. Het is ook zo, dat in het ziekenhuis alles opgesplitst is, dat is, er is makkelijk contact met verplegenden, met de geneesheren, omdat die multidisciplinair samenwerken. »

Quote retrieved from a focus group.

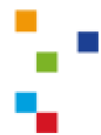
« Hier is het probleem van een vrouw die naar 5,6 steden gaat. Wat hebben we hier gedaan: info gegeven aan kerkgemeenschappen, en met OCMW X afgesproken om toch een verblijfplaats in X te hebben en van een medische kaart krijgen prioriteit gemaakt en besloten om ernst te evalueren. Ze zal op een bepaald moment zich op spoed aanbieden en dan zal de zorg veel duurder zijn. Soms moet je durven luidop benoemen en u niet wegsteken achter bureaucratie. »

Quote retrieved from a focus group

A few health professionals propose the development of **specific health centres** for UM. It would imply that UM would not be cared for in mainstream health care services, but reoriented to specific health centres. However, this kind of solutions was not supported by all health professionals as supporting specific health centres for UM may lead to the development of a negative parallel health care system, inducing more exclusion and discrimination. Other professionals suggest the development of **fix-payment system**, covering all health care needs of the UM, including specialty care and mental health care.

« Pourquoi pas imaginer un centre spécifique avec un médecin spécifique, une équipe médicale, des soignants, des assistants sociaux, dédiés à l'AMU qui seraient habitués aux règles, qui sauraient bien s'occuper d'eux, donc uniquement pour les personnes sans-papiers. »

Quote retrieved from a focus group



5.4.2.4 Appropriate decisions

Solutions to discretionary decisions – if needed – partly depend upon the solutions of the three previous problems. The existence of discretionary zones may be beneficial to the UM, leaving room for flexible and individualised approach.[56] Moreover, discretionary decisions heavily depend on the attitudes of individuals and existing norms in a setting. Modifying norms is a long-term process. In that context, there is no direct solution to discretionary decisions, as most of the solutions also depend on individual attitudes.

First of all, **clarifying the definition of "UMA**" and **improving the quality of information** delivered to CPAS – OCMW and health care professionals regarding UMA are the two indispensable solutions that may solve problems of discretionary decisions.

> *« Je ne pense pas que la loi sur la prise en charge pour l'AMU soit mal faite même si il y a des choses à rectifier, surtout au niveau des termes utilisés et de la manière dont on cadre la prise en charge mais l'application est laissée vraiment à l'interprétation de chaque CPAS – OCMW et chaque CPAS – OCMW construit l'opérationnalisation de l'AMU et là on a des disparités énormes d'une commune à l'autre, ce qui génère des difficultés pour les personnes mais aussi pour les grandes villes car les personnes qui sont pas dans l'agglomération vont retourner vers les centres urbains où on est sûr que la prise en charge sera là. »*
>
> Quote retrieved from a focus group

Second, the **standardisation of the procedures across municipalities** is also reported as a possible way to decrease discretionary decisions. However, this standardisation should guarantee that the harmonised outcomes won't disfavour UM or lead to an overall decrease in the care that is made accessible for UM. Indeed, some health care practitioners report that they fear that a minimal "package" of health care may as such become the maximal level of health care that an UM is allowed to receive.

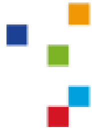
> *« Il faudrait un système homogène dans son fonctionnement et dans son règlement. Uniformiser les procédures et qu'il n'y ait pas trop d'interprétations possibles. »*
>
> Quote retrieved from a focus group

Third, participants in the focus group discussions suggest that the **Law of 1965 related to social aid should be updated** in order to take into account the evolution of the society and the social aid since the 1960s. Despite the fact that several competences of the Law of 1965 have been transferred to the federated entities, the Law of 1965 has never been modified accordingly.

> *« La loi elle date de 1965 et elle n'est absolument plus actuelle. En '65, il y avait pas le nombre d'illégaux qu'on a aujourd'hui, 50 ans plus tard. Or on fonctionne toujours avec cette loi-là, Toute cette loi est obsolète et en même temps on ne veut pas y toucher et le ministère via des circulaires impose en plus d'autres restrictions. »*
>
> Quote retrieved from a focus group

Fourth, a final solution to avoid discretionary decisions being taken suggested by HCP is the **inclusion of health care to UM in the accreditation of hospitals**. Paying attention to vulnerable populations could be inserted in quality indicators forcing the health services to develop specific attention to those persons imbedded in protocols. Currently, there is a pilot-testing of "Equity Standards" in several hospitals and health services, including in Belgium[ww]. These Equity Standards may serve as a template to better integrate vulnerable populations such as UM within health services. [57, 58] This kind of solution may be assorted by a pay-for-performance scheme in which a part of the funding of the services is related to the achievement of specific clinical goals for specific target groups. Previous studies showed the positive impact of pay-for-performance system on intermediate health outcomes among ethnic minorities (see e.g. [59]). This may also broaden the spectrum of services available for UM, as most of the

[ww] The Belgian pilot-testing is coordinated by the Intercultural Mediation cell of the FPS Public Health, Food Safety and Environment.



UM are concentrated in community health services ("wijkgezondheidscentra" and "maisons médicales") or in public hospitals.

> *« Het zou beter zijn om dringende medische hulp in accreditatie van ziekenhuizen op te nemen. »*
>
> Quote retrieved from a focus group

Fifth, **going to court** is a practice being pursued by several stakeholders at the moment and which was reported as last intervention when CPAS – OCMW breach the law and if dialogue does not solve the issue. NGOs go to court against the CPAS – OCMW in case of refusal but the procedure is complex and costly for UM. Moreover, CPAS – OCMW systematically refuse to pay the fine and appeal the decision. Based on their experience, some health professionals report that condemning the CPAS – OCMW to pay penalties when appealing a court decision was somehow a solution to prevent CPAS – OCMW to refuse covering health care fees. However, the success of this solution heavily depends on the personality of the judge at the Labour Court. Also, social services of healthcare providers emphasise that, they should be called upon that, first by dialogue and if necessary by court interventions.

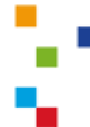
> *« We moeten een gesprek met de instantie aangaan: wat staat in de wet en heb je het recht om te zeggen dat het 4 keer of 2 keer is? Ze zeggen neen dus dan moet je persoonlijk durven motivatie vragen. Probleem is dat het nu gedoogd wordt, dat is een vrijgeleide van interpretatie van de wet tussen de verschillende OCMW. En het is aan ons, die de patiënt vertegenwoordigen, om dat aan de kaak te stellen. Misbruiken van OCMW moet gemeld worden zonder naam en toenaam van individuen." »*
>
> Quote retrieved from a focus group

Besides these five solutions, other, rather "**cosmetic measures**" were formulated **to reduce effects of harm done**, which we discuss here in the light of the current legislation.

First, UM report that **moving to a more "friendly" CPAS – OCMW** when facing negative discretionary decisions is now a solution. HCP also report that sometimes moving is the only solution when facing negatives attitudes from the CPAS – OCMW. This practice appears to be common and sometimes supported by the social assistants of the CPAS – OCMW themselves but this could be not considered as a sustainable solution. When supported by a social assistant, this practice is legally condemnable. Indeed, the Law of 1965 regarding support provided by CPAS – OCMW states that:

> *« Lorsqu'un membre ou un agent (d'un centre public d'aide sociale) a, directement ou indirectement, soit par des promesses, menaces, abus d'autorité ou de pouvoir, soit par inertie ou autrement, engagé ou contraint un indigent à quitter le territoire d'une commune, ou à y rester ou encore à s'installer dans une commune, le Ministre qui a l'assistance publique dans ses attributions, peut décider de mettre à charge de (ce centre public d'aide sociale) les frais déboursés par (le centre public d'aide sociale secourant) sans que cette charge puisse excéder le montant des secours accordés pendant un an[xx]. »*
>
> Loi du 2 avril 1965 relative à la prise en charge des secours accordés par les centres publics d'aide sociale, Chapitre III, Art.19. §1er.

[xx] See chapter III: Sanctions, Art. 19. § 1er. 2 AVRIL 1965. - [Loi relative à la prise en charge des secours accordés par les centres publics d'aide sociale.] / 2 APRIL 1965. - [Wet betreffende het ten laste nemen van de steun verleend door de openbare centra voor maatschappelijk welzijn.]



« Wanneer een lid of een (personeelslid) van een (openbaar centrum voor maatschappelijk welzijn) rechtstreeks of onrechtstreeks, hetzij door beloften, bedreigingen, misbruik van gezag of van macht, hetzij door niet op te treden of anderszins, een behoeftige ertoe aangezet of gedwongen heeft het grondgebied van een gemeente te verlaten of aldaar te blijven, of nog zich in een gemeente te vestigen, kan de Minister tot wiens bevoegdheid de openbare onderstand behoort, de door (het steunverlenend openbaar centrum voor maatschappelijk welzijn) gemaakte kosten ten laste leggen van (het betrokken openbaar centrum voor maatschappelijk welzijn), met dien verstande dat niet meer dan de tijdens één jaar verleende steun mag worden ten laste gelegd. »

Wet 2 april 1965 betreffende het ten laste nemen van de steun verleend door de openbare centra voor maatschappelijk, Hoofdstuk **III**, Art.19. §1st

Consequently, the provision of information about voluntary or involuntary "illegal" practices should be better included in the training / lifelong learning of social assistants to prevent such situations. This may be helped by the provision of clear and up-to-date information from the public authorities to the social assistants in CPAS – OCMW. Besides, adapting the Law of 1965 related to social aid to the evolution of the society may help to clarify the situation and the legal aspects surrounding social aid in Belgium.

Second, to prevent the (negative) discretionary role of social workers, some health professionals argue that it should be supported that **controlling applications for UMA by an independent medical doctor within CPAS – OCMW**. However, this solution is not supported in all focus groups. Several participants recall that the CPAS – OCMW should trust the HCP and are not in a position to question the relevance of a prescription. The CPAS – OCMW should stick to his role of providing social aid, conducting the social survey and thus focusing on aspects related to indigence.

« Het is volledig stom, als een behandeling door een dokter is voorgeschreven, dat is niet om vervelend te doen of om OCMW in moeilijke toestand te zetten. Artsen zijn aandachtig om minimale behandeling te geven, en geneesmiddelen die goed zijn voor de mensen in de context; dus ja, terugbetaling van de consultatie is geweigerd, maar zonder behandeling heeft de consultatie bijna geen zin." »

Quote retrieved from a focus group

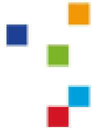
« Het OCMW moet enkel oordelen of mensen illegaal zijn of niet en of ze behoeftig zijn of niet. Dat is hun taak en de rest is aan artsen om te bepalen wat dringend is en moet behandeld worden. OCMW moet een kaart geven, en al of niet behandelen, daar beslissen zij niet over." »

Quote retrieved from a focus group

Finally, some health professionals report that **bypassing the CPAS – OCMW** when delivering UMA is a possible solution. Bypassing the mainstream system is reported in a previous study that investigated access to health care for UM.[49] Indeed, health professionals tend to exert bedside rationing when confronted to UM patients, relying on "do-it-yourself" solutions such as giving samples of medications or offering free health care.

« On essaye de négocier et puis on fait appel à la débrouille. On doit débourser nous-même parfois, on se démerde. On donne des échantillons etc. […] Pareil pour l'hôpital, on donne des béquilles puisqu'elles sont pas prises en charge, si on veut faire sortir les gens, donc on a un stock. »

Quote retrieved from a focus group



5.5 Discussion

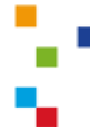
This SWOT analysis provides us with a unique insight in the perspectives of the key persons and organisations involved in the procedure of Urgent Medical Aid for undocumented migrants in Belgium, namely support organisations, health care professionals and managers providing services in the context of Urgent Medical Aid, and, above all undocumented migrants themselves. Although the latter are clearly the most important informants in this specific matter, the direct involvement of this group is often overlooked in the studies on health care for undocumented migrants. By listening to their experiences and views, we gain deeper understanding of the strengths and the weaknesses of this procedure in its actual implementation.

In this study, we first have put the information collected from the three groups of participants (i.e., the support and civil society organisations (key stakeholders), the undocumented migrants and the health care professionals) in three separate SWOT analyses, indicating the 'Strengths', 'Weaknesses', 'Opportunities' and 'Threats' related to the procedure of Urgent Medical Aid for undocumented migrants in Belgium (see appendix). This gives us insight into the main themes and the particular views of each group. Next, we compared the three SWOT matrices for each of the subthemes of the legal and political framework and procedures on the one hand, and of the provision and quality of urgent medical aid for undocumented migrants on the other hand. This comparison reveals that not all subthemes are perceived as equally important by all groups. For example, few undocumented migrants refer to the definition or the national legislation when discussing urgent medical aid, while key informants and HCP stress that these aspects should be tackled in order to improve the procedures. At the same time, we found considerable overlap between the views of these distinct groups, showing that specific issues of the procedure are experienced or perceived in the same way, and can therefore be considered as a valid representation of the UMA procedure as it is implemented. These results are also illustrative of the personal experience of each actor, and how his/her role in the UMA process affects his/her perception of the problems and solutions.

When analysing the SWOT matrices of our different participants, four key themes emerged which are cutting across the legal and political frameworks as well as across the quality elements of the provided care. We consider them to be the key bottlenecks linking the most important problems and challenges in the current implementation of urgent medical aid for undocumented migrants in Belgium, namely (1) definition of urgent medical aid, (2) information and communication, (3) application of procedures, and (4) decision-making process.

***1. Definition of urgent medical aid*: A first key knot we identified relates to the semantic ambiguity of the term "urgent medical aid", which is often interpreted as "emergency medical care", although this is not stipulated in the legal description of what urgent medical aid entails. Our results show that this ambiguity impacts the health-seeking behaviour of undocumented migrants, and the decision-making process of both the health care providers and the CPAS – OCMW, which results in suboptimal care, refusal of care, or neglect of the severity of certain health problems, particularly mental health problems. Moreover, certain vulnerable groups, such as pregnant women, new-borns and children, are more exposed to health problems, but seem to receive a low level of health care, especially in terms of preventive health care. We argue that this forms a consequence of how narrow 'health' is perceived in the matter of UMA, relating it merely to reducing disease and infirmity, rather than being directed at health promotion. This confirms earlier findings of migrant health policies in the EU.**[45, 46]

- **Suggested measures to overcome this ambiguity were to replace the term "urgent medical aid" by "necessary health aid", and to create more transparency and coherence by harmonisation of what is covered by UMA and what not. We also found consensus about the need to open up the current health care package to a more inclusive one in specific situations of chronic diseases, pregnancy, new-borns and children's health, as well as to include social determinants of health and to find other types of financial guarantees, of which universal health coverage was cited as a very evident one. Finally, several participants stressed that health is a human right, and that everybody should have equal access to health care, regardless of the legal status one holds.**



***2. Information and communication*: Our results demonstrate that both UM as well as health care providers lack clear information about what UMA entails and which procedural and administrative steps have to be followed. Both parties stated that they had to 'learn by doing', which often resulted in symptoms of stress, in miscomprehension, and overall late provision of care. Limited health literacy at the side of undocumented migrants was sometimes noted, but limited knowledge about global health and intercultural competent care is something found at the health providers side as well. At the side of the CPAS – OCMW, health care professionals and managers stressed that many social workers lack basic communication and professional skills, that they often do not inform nor communicate the justification of their decisions, and that they are trespassing their authority and responsibilities by requiring medical information of the UM before taking a decision.**

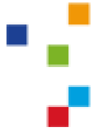
- **As a solution to this lack of information and to the communication problems, informants put forward that translation and interpretation should be considered as key elements of quality of care and necessary to ensure patient's rights. Furthermore, it is stressed that communication skills of CPAS – OCMW staff should be improved through training in giving "bad news", in intercultural communication and in empathic conversations on all sorts of sensitive issues, including sexual and reproductive health. This is consistent with previous recommendations in Belgium [25, 26, 52-54]. Finally, further sensitisation on UMA and on global health, both in the curricula of all healthcare providers as in trainings once they are at work was asked for[yy].**

***3. Application of procedures*: Because of the unclear definition of UMA, the lack of (appropriate) communication, and many different steps to take, the application of the procedure of Urgent Medical Aid is perceived as highly complex, engendering uncertainty for both undocumented migrants and health care professionals about the coverage and the payment of medical costs, leading to unnecessary anxiety for the undocumented migrants, as well as to delays in the provision of care to the UM. The need to provide an address to the CPAS – OCMW in the framework of the social survey is pointed out as the main hindrance for UM, and is often cited as the cause of their non-collaboration and therefore leading to refusal of UMA.**

- **Many participants plea to consider the precarious situation of undocumented migrants, fearing for their safety and often relying on relatives' solidarity to have a proper housing, when CPAS – OCMW request their address. Supporting UM in providing neutral convenience addresses could be a pist of solution. Again, further adaptations of the UMA procedures should pay more attention to human dignity and well-being of the UM.**

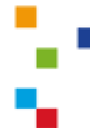
***4. Decision-making process*: Finally, the existence of discretionary decisions at all levels of the UMA procedure is the consequence of the three pre-cited problems. Discretionary decisions were reported inside and between health services, including pharmacies, and inside and between CPAS – OCMW. For the undocumented migrants, these discretionary decisions can lead to unequal or inadequate treatments, they may be source of conflicts between health care providers and CPAS – OCMW, and may jeopardise the initial objective of the UMA procedure: providing health care to UM.**

[yy] The Interfederal Center for Equal Opportunities is currently launching a workgroup on the implementation of transcultural competences in the training of the health care professionals – CARE.



- **Solving the problems related to the definition of UMA, to the Royal Decree of 1996, to communication and information and the complexity of the procedures may help to reduce the discretionary decisions and lead to more adequate applications of the procedure. Further, harmonisation of the procedures between CPAS – OCMW, updating the Law of 1965, going to court to protest against unfair decisions of the CPAS – OCMW, and including health care of the UM in the accreditation of the health services may also contribute to solve the problems related to discretionary decisions. This last solution – including health care of undocumented migrants in the accreditation of health services – may also benefit other vulnerable populations who are relying on health care from the CPAS – OCMW, such as Belgian citizens with a low socio-economic status. Moreover, the Equity Standards, currently pilot-tested in several Belgian hospitals, may serve as a template to achieve greater equity for all patients in Belgium, without any distinction of legal status.[57, 58]**

In conclusion, following numerous NGOs and international organisations, we want to call for increased attention regarding health care for 'vulnerable groups', such as undocumented migrants, and this as a fundamental choice based on a human rights perspective. Consequently, any further adaptation to the UMA procedures should include a patient-centred perspective, based on people's universal human rights and should strive to health as a state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity", as is put forward by WHO. Hereby, we want to highlight that some of the problems in the procedure as mentioned in this study already have a long history, but that some relatively 'easy' solutions to some of these problems exist. However, we need to be careful that these changes are not just 'cosmetic measures', in particular not in domains where in-depth and fundamental changes are largely needed. We hereby want to stress that the current UMA procedure generates lots of stress and anxiety for undocumented migrants, because of the uncertainty, complexity and, unfortunately, sometimes even disrespectful attitudes of some social workers or health professionals. We here want to point at the finding that CPAS – OCMW seem to not always do what they have to do, their sometimes long-lasting procedures may not be fast enough to address medical needs, with the risk to increase the burden of diseases. Furthermore, our study finds that CPAS – OCMW fulfil two aspects of the UMA procedure: (1) they are the gatekeepers through granting undocumented migrants access to urgent medical aid (or not); and (2) they are the decision-makers in covering (or not) each specific request for health care or treatment. We here could question whether it should be the responsibility of the CPAS – OCMW to activate the right to UMA, and whether all of them are skilled enough to make these decisions. At least, this leads to a plea to remind CPAS – OCMW of their specific role in this procedure (checking the UM's address, conducting the social inquiry), stressing that the main gatekeeping role of the UMA procedure must be in the hands of medical doctors. Yet, another possibility is to reorganize this responsibility and decision-making role and shift it to another actor. MediPrima is likely to become an instrument supportive to this scenario.



6 LESSONS LEARNED FROM OTHER COUNTRIES

6.1 Literature review

This chapter was authored by Marie Dauvrin (UCL), Ines Keygnaert (ICRH-UGent), Birgit Kerstens (UGent), Julie Gysen (UCL), Ilse Derluyn (UGent), and Vincent Lorant (UCL)

6.1.1 Objective

In order to frame this study into existing literature, we conducted a short, but systematic research of the literature related to Urgent Medical Aid (UMA) and the access to health care for undocumented migrants (UM). This short literature review adds to previous national and international studies that investigated these two topics.[27, 45, 46, 49, 50, 55, 56, 60] By conducting this literature review, the objective was to identify the main interventions aiming at increasing the access to health care for undocumented migrants at the institutional level.

6.1.2 Methodology of the literature review

Search strategy and data extraction

In January and February 2015, we searched throughout three databases, Scopus, PubMed and Cairn, to identify peer-reviewed and indexed publications on the topic. In order to also identify so-called 'grey literature', we used Google Scholar, and the websites of relevant institutions and associations concerned with irregular migrants. These institutions and associations were identified based on the expertise of the research team and the advices of the stakeholders during the advisory board meeting. We also searched the references of key publications previously identified in the literature search. The search equation was initially developed for PubMed and then adapted for the other databases, based on the P.I.C.O. method (Patient Intervention Comparison Outcomes).[61]

We did not use the MESH term in the PubMed database as the MESH term for irregular migrants is broader than the absence of legal permit of residence[zz]. However, as our first equation retrieved less than 800 references in PubMed with the keywords related to the population of interest, we did not use the interventions or outcomes in the search equation, but rather applied exclusion and inclusion criteria to the retrieved results. We searched all possible variations in the term 'irregular migrants', and used truncated search terms to increase the sensitivity of the results.

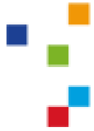
The data extraction procedure was based on the criteria of the Centre for Reviews and Dissemination: characteristics of the study, participants, intervention, and setting and of the outcome data and results.[62] Citations and abstracts were stored and tracked in EndNote X7 / EndNote Online. We developed standardised forms in Excel spreadsheets to support the analysis of the results.

Study selection

Two reviewers carried out the revision process (MD, JG). Each reviewer first checked the title and the abstract of the study, based on the inclusion and exclusion criteria (see Figure 11 for the details of the revision process). Inclusion criteria were sorted in two categories: articles-related criteria and interventions-related criteria. Articles-related criteria included: language of publication (French, Dutch or English), time-span (from 2000 till present), countries of origin of the studies (European Union, United States of America, Canada and Australia), and document type (reviews and articles, reports from non-governmental organisation).

Interventions-related criteria were: population of the studies (undocumented migrants, all ages, adults and children); at least 50% of the population involved in the study is defined as UM (in order to avoid studies where UM are accidently recruited as participants, e.g. in deprived neighbourhoods); AND interventions with a clear focus on undocumented migrants or recommendations with a clear focus on access to health care for undocumented migrants; AND interventions focusing on the

[zz] « Undocumented migrants » is indexed under « Transients and migrants », defined as «people who frequently change their place of residence » (MeSH database 2015).



structural/organisational/institutional/financial/political levels; AND improved access to health care system as main outcome.

Exclusion criteria were related to document type (editorials, commentaries, opinions, letters), absence of abstract, no description of the intervention, no specific outcomes of the intervention for irregular migrants, interventions focusing on language, culture or personal and individual factors (e.g. health beliefs), and interventions aiming at educating patients (health literacy).

At the end of the review process, abstracts were sorted in three categories: 'A' for inclusion, 'R' for excluded abstracts, and 'C' for divergent coding. Full texts of papers in categories A and C were then reviewed with specific attention to the interventions and outcomes of the studies. Divergent coding was discussed between the reviewers and a final decision was made by consensus.

Classification of the interventions

The classification of the interventions was based on the "7B Framework" as developed by Roose and De Bie in the context of youth care.[44aaa] Table 5 provides an overview of the 7B framework and its dimensions. Articulated around 7 key dimensions related to access to health and/or social care, the 7B framework has been developed in Flanders in order to identify in which aspects access to health care services could be improved. This model was selected as it was developed in Belgium and thus is likely to integrate the specificities of the national context. Moreover, this framework is currently used by local associations (see e.g. the work realised by Veerle Cortebeeck with the VVSG), which is likely to support the process of knowledge translation of the findings of this review.

Besides, access to health care is also organised across several levels in the health care system.[63] The interventions were analysed according to the distinct levels of 'micro', 'meso', 'exo' and 'macro' levels.[64]

[aaa] 7B stands for Bereikbaarheid (Reachability), Bruikbaarheid (Functionality), Beschikbaarheid (Availability), Bekendheid (Notoriety), Betaalbaarheid (Affordability), Betrouwbaarheid (Reliability) and Begrijpelijkheid (Comprehensibility)

Table 5 – The 7B framework on access to health care

Dimensions	Definition of the dimension	Examples of interventions
Reachability	(Lack of) thresholds when care is needed	Absence of gatekeeping system
Functionality	Extent to which the patient experiences the care as supportive	Single point of entry
Availability	Existence of a supply and of (social) services which can be called upon for matters that do not relate directly to the assessed problem	Existence of dental care service in first line of care
knowledge	Extent to which the patient is aware of the existence of the services	Information is provided to the patients through other services (e.g. schools)
Affordability	Financial and other costs that patient may encounter	Fees for services are based on the income of the patient
Reliability	Extent to which the patient can trust the services and the professionals	No need to provide ID documents
Comprehensibility	Extent to which the patient is aware of the reason for the intervention and the way in which the problem should be approached	Provision of cultural mediators or social interpreters

Adapted from Roose & De Bie (2003)[44].

6.1.3 Results

Overall results

We reviewed 1,403 papers; 14 papers matched our inclusion criteria. Most of the excluded papers described the health status of undocumented migrants and the relationship between their legal and their health status. Besides, we also found numerous interventions focusing on the personal accessibility of health care services (e.g., use of interpreters or mediators, specific health promotion programs). Figure 11 presents the detailed review process of the literature review.

Table 6 presents the names of the authors, titles of the papers, years of publication, country of the studies, and objectives of the interventions in the 14 studies included in the literature review.

Nine studies were conducted in the USA, two were conducted between USA and Mexico, and the three remaining in Europe (two international studies and one in Spain). The studies were published in 2014 (n=3), 2013 (n=3), 2012 (n=3), 2010 (n=1), 2009 (n=1), 2007 (n=2), and 2003 (n=1). Twelve studies out of 14 had a qualitative design, including qualitative interviews (n=5), analysis of case-studies (n=3), literature reviews (n=2), stakeholder analysis (n=2) and focus groups (n=1). The two quantitative studies were a web-based survey (Gonzales et al. 2014) and a community-based survey (Gonzales-Block et al. 2014).

Five studies concerned Latino UM living in the USA, two studies UM from Mexico and one study UM from Ecuador. The 7 remaining studies did not look at a specific country of origin of the UM.

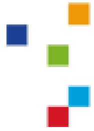


Figure 11 – Flowchart of the process

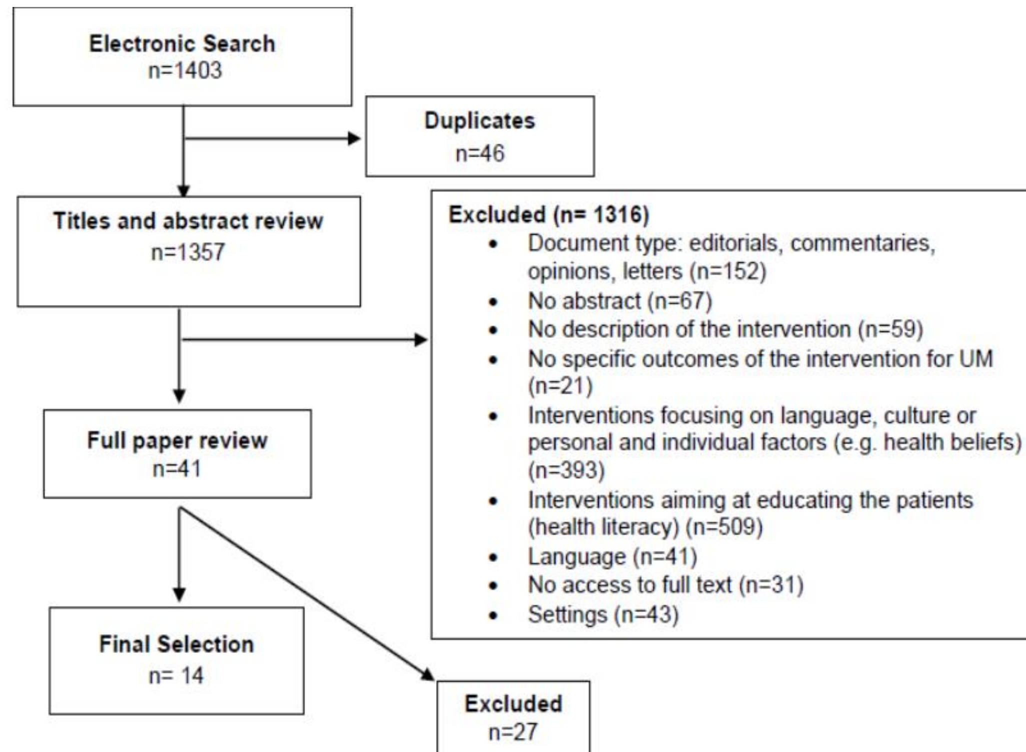
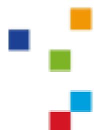


Table 6 – Details on the 14 studies included in the literature review (n=14)

Authors	Title	Year	Country	Objective
Arredondo et al.	Health insurance for undocumented immigrants: opportunities and barriers on the Mexican side of the US border	2012	Mexico	To identify opportunities, barriers and challenges in Mexico's policy networks for the development of health care programs for undocumented migrants in the USA and their families.
de Graauw	Municipal ID Cards for Undocumented Immigrants: Local Bureaucratic Membership in a Federal System	2014	USA	To examine the municipal ID card programs in New Haven and San Francisco.
Frates et al.	Models and momentum for insuring low-income, undocumented immigrant children in California	2003	USA	To review a two-year demonstration project to provide subsidised health insurance coverage to undocumented children through five non-profit organisations.
Gonzales et al.	Becoming DACAmented: Assessing the Short-Term Benefits of Deferred Action for Childhood Arrivals (DACA)	2014	USA	To investigate variations in how undocumented young adults benefit from DACA.
González Block et al.	Redressing the limitations of the affordable care act for Mexican immigrants through bi-national health insurance: A willingness to pay study in Los Angeles	2014	USA	To analyse factors associated with willingness to pay for cross-border, bi-national health insurance (BHI) among Mexican immigrants in the US.
Gray & van Ginneken	Health care for undocumented migrants: European approaches	2012	USA	To review policies aiming at providing health care for undocumented migrants in seven European countries
Liebert & Ameringer	The health care safety net and the affordable care act: Implications for Hispanic immigrants	2013	Europe	To show the use of free clinics for basic health care services among Hispanic immigrants
Martinez et al.	Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review	2013	USA	To assess and understand how these immigration policies and laws may affect both access to health services and health outcomes among undocumented immigrants
Nandi, Loue & Galea	Expanding the universe of universal coverage: The population health argument for increasing coverage for immigrants	2009	USA	To review the health status and access to health services among immigrant populations in the USA
Ruiz & Briones-Chavez	How to improve the health of undocumented Latino immigrants with HIV in New Orleans: an agenda for action	2010	USA	To analyse and diagnose health situations in documented and undocumented communities with HIV/AIDS in the city of New Orleans; to advocate strategies to improve health care access among documented and undocumented immigrants.
Stevens et al.	Children's health initiatives in California: The experiences of local coalitions pursuing universal coverage for children	2007	USA	To examine the progress of Children's health initiatives (CHIs) toward enrolling all eligible children; variations in program design, financing, and sustainability; the leadership and composition of CHI coalitions; outreach



Authors	Title	Year	Country	Objective
				strategies; provider capacity; and experiences with a state-wide Healthy Kids legislative initiative.
Strassmayr et al.	Mental health care for irregular migrants in Europe: barriers and how they are overcome	2012	USA	To identify barriers to mental health care for IMs, and to explore ways by which these barriers can be overcome in practice.
Torres-Cantero et al.	Health care provision for illegal migrants: may health policy make a difference?	2007	Europe	To assess whether sick legal and illegal migrants are now using health services with similar frequency irrespective of their legal status
Wallace et al.	Improving access to health care for undocumented immigrants in the United States	2013	Spain	To identify policies that increase access to health care for undocumented Mexican immigrants.

Names of the authors, years of publication, country of the studies and objectives of the interventions.

Interventions

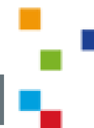
Interventions mainly aimed at improving access to health care through insurance coverage (n=5). The insurance system could have different forms, such as a bi-national health insurance system (only reported between Mexico and USA, n=2). The health insurance could be delivered to all UM or being limited to children. However, “open-door” services and “safety net” system were also identified as interventions likely to improve access to health care for UM. These two types of interventions mainly consisted in providing “free” health care, independently of the existence of an insurance system.

Three studies reported the role played by policies in improving access to health care for undocumented migrants. Among these three studies, two of the policies were health policies, while the remaining policy was related to immigration. De Graauw and colleagues (2014) assessed a municipal program providing identity cards to UM in order to help them to access the health services.[65]

Three studies investigated the question of access to health care for UM from multiple perspectives.[66-68] At the political level in Europe, Gray and Van Ginneken (2012) identified three dimensions guiding policy strategies: 1) focusing on specific groups; 2) focusing on specific services (e.g., control of transmissible diseases); and 3) focusing on specific funding policies.[66] Strassmayr and colleagues (2012) pointed out that access to mental health services in Europe mainly depended on the “good will” of the health professionals.[68] Access to mental health services was likely to be supported by institutional conventions, especially when it came to issues of covering the medical fees. In their “agenda for action”, Ruiz and Briones-Chavez (2010) focused on UM Latino immigrants with HIV.[67] Interventions were mainly displayed at organisational level: health promotion and education, outreach programs – with an emphasis on culturally-sensitive health care – and development of research centres.

The 7B framework

The 7B components identified in each study are presented in appendix. A same study could report several components of the 7B framework. Most interventions aimed at improving the reachability of the services (n=11). Examples of interventions were “safety net” programs, “open doors” services or health policies granting access to health care for UM. Ten interventions aimed at improving the affordability of health care, such as bi-national health insurances or specific insurance systems for children. Comprehensibility was targeted in 7 interventions, by providing linguistically and culturally adapted interventions. Knowledge and reliability were developed in 6 interventions. It involved, for example, the support of an NGO or the Catholic Church when working with Latino communities. Four interventions targeted functionality by, amongst others, developing specific services for specific groups, such as children. Three interventions supported the availability of services through developing telemedicine.



Additional results

Although our review did not primarily aim at identifying health problems, we identified the three most frequent health problems: (1) mental health issues, (2) sexual and reproductive health issues (especially for women, although this theme should also be considered for men and young boys), with the particular lens of pregnancy for women, and (3) work-related diseases. High-risk profiles are children, pregnant women, and victims of violence and human trafficking. However, it seems that, as our literature search identified mostly US literature, the issue of human trafficking and violence is rather absent. Besides, a recent literature review showed that if sexual and reproductive health is dealt with in EU policies, it mostly regards maternity care and HIV, while most of the migrants are neither pregnant nor HIV-infected.[45] Moreover, the issue of violence is predominantly viewed through a limited lens of female genital mutilation and trafficking.[69] Gray and Van Ginneken (2012) hereby stated that questions related to human rights are more prominent in Europe than in the US.[66]

6.1.3.1 Discussion

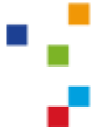
This systematic literature review aimed at identifying the main interventions which are aiming at improving the access to health care for undocumented migrants, with a focus on the structural and organisational levels. Fourteen papers matched our inclusion criteria.

At macro level, several authors highlighted that health policies on medical cards and free medical care in equal terms as for legal migrants, and policies and legislation that support the access to mental health care are likely to improve the reachability of health care. Moreover, tailored administrative procedures may help to solve the frequent inability of UM to prove their identity, their (lack of) resources or their residency. Reachability could be improved by expanding outreach services and enrolments into existing programs or to set up systems of registration at the municipality to receive health care and municipal ID cards (these are identity cards, providing access to a range of public services, not limited to health services only). This type of interventions may also improve the knowledge of the health care services: indeed, combining access to health care with other integration policies, such as driver's licenses, banking, and renting, was reported as a relevant strategy.[70] Other interventions were educational outreach campaigns to encourage the use of benefits, proactive member education and orientation processes. Affordability could be improved through universal care coverage (publicly financed insurance coverage), allowing UM purchasing health insurance or even having temporary social security numbers. Other strategies included the mix of internal and external private and public funding to sustain the programs over time, separated tax-funded system, and National Health Service or employer mandated health insurance. The reliability can be enhanced by working on immigration policies, and especially antidiscrimination policies, but also by involving political stakeholders, and governmental stakeholders at local level.

The findings highlight the role of the national context in the interventions that aim to improve health care for UM. Translating this to the Belgian context, the Belgian procedure of UMA could be considered as a form of health insurance coverage, since there is a pooling of risks and a sharing of payments. In this context, the challenges in Belgium are more related to the knowledge and reliability of the services than to its affordability. However, the effective access in Belgium could be improved, especially because of the gap between the legal dispositions and the current practices in services.[71]

At exo level[bbb], reachability was improved thanks to safety net programs and services (such as expanded community access with community health centres, free clinics), to "open door" services (no condition to access the service) and mobile clinics. Integrated delivery systems, as single points of entry, enhanced the extent to which the patient experiences the care as supportive. Availability of the health services was improved through the development of specific services (e.g., charity funded or free clinics), and through broadening the number of health professionals and suppliers of public health services. Furthermore, health care professionals can build referral systems to enhance the knowledge of health services. Improving the affordability of care can be achieved through the provision of services outside the mainstream government funding, such as free clinics or free

[bbb] Exo level="linkages and processes taking place between two or more settings, at least one of which does not contain the developing person, but in which events occur that indirectly influence processes within the immediate setting in which the developing person lives" (in Bronfenbrenner, 1994, p 40)



health care provided within the safety net. Finally, service-funded interpreters and training of health professionals were reported as likely to enhance the comprehensibility of health care services. Previous studies in Belgium recommended the provision of professional interpreters as a way to improve access and quality of care for migrant populations, including UM.[25, 53, 56]

Our literature review has some limitations. First, the definition of undocumented migrants depends on the context of a country [3]. As stated in the methodology, “undocumented migrants” was included under the MESH term “Transients & Migrants”. However, this definition mainly focuses on the fact that people often move, rather than on the absence of a legal permit to stay in a country, which is the situation of UM in Belgium. This difference of definition between the indexed databases and the operational definition of UM in Belgium and Europe may lead to an underestimation of the number of papers. However, the search equation includes variations of the key words, preventing the bias of underestimation. Second, eligibility of the papers was limited to French, Dutch and English and to published indexed studies. It is likely that more interventions exist that are not yet published. However, Egger and colleagues (2003) suggested that these limitations do not affect substantially the results of a review.[72] Besides, as the political context plays a role in the development of interventions supporting access to health care for UM, it is likely that national journals – in national languages – report additional interventions.

This short literature review highlights that Belgium already offers a comprehensive legal coverage of health care needs of UM when compared to other countries where the question of providing insurance remains the main issue. The main challenge for Belgium will be the effective achievement of the goals of the UMA procedure: ensuring that UM will receive the health care that they need.

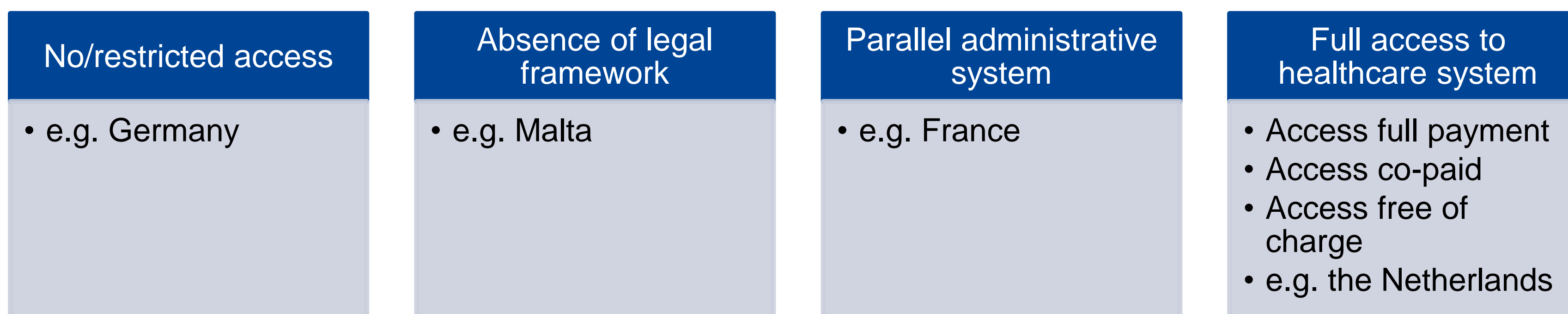
6.2 Comparative analysis of selected European countries

Several reports described already the current legislations in a broad range of European countries.[2, 73-75] This section does not aim to update these same descriptions, but to examine the potential benefits of existing organizational initiatives from abroad for alleviating the current bottlenecks in UMA in Belgium. The synthesis of the main similarities and differences with the current Belgian practice, serves as a basis for the discussion with the stakeholders on potential strategies for Belgium.

The existing comparative analyses were used as source for the technical sheets per country completed with information on governmental websites.

A common framework to analyze transversally different health systems, is taking the access to healthcare as a starting point, with a further subdivision in financial access and type of healthcare. The access to healthcare can be seen as a continuum ranging from no access at all to complete access to the current healthcare system (see Figure 11).

Figure 12 – Typology of access to healthcare for undocumented migrants across European countries



Source: Based on multiple comparative studies on the access to health care for undocumented migrants[2, 73-75]

No access to healthcare system

An example of a country with a very restricted access to healthcare is **Germany**.[30] The legal framework recognizes the same entitlements to undocumented migrants as to asylum seekers residing for less than forty eight months (i.e. list of indications and services). The main barrier, which restricts all access to healthcare services, is the legal duty for the public administrative institutions, including the social welfare centers to denounce undocumented migrants to the Foreigners Office. Healthcare providers and public hospitals are excluded from this obligation.

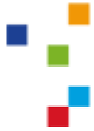
However, if hospital administration fears that the patient is unable to pay the bill, this will be reported to the Social Security Office and could subsequently be reported to the Foreigners Office. A new regulation has excluded the social welfare centers from the duty to denounce in case of reimbursement for emergency situations.[30] There are some local initiatives that facilitate access to health care for undocumented migrants.

Different to Germany where the obligation to denounce is not directly imposed on the healthcare providers, in **Romania** healthcare providers are obliged to breach their duty of confidentiality when it is considered that they are facilitating the illegal stay of undocumented migrants.[75]

Other countries with a (previous) restrictive access to healthcare are Sweden and Denmark.[23]

In **Denmark**, undocumented migrants have the right to free emergency care but the doctors are not obligated to treat non-emergency cases. For such non-emergency services, payment can be requested. According to the Danish Aliens Act, UM may request treatment from the Danish Immigration Service, but in practice this option is rarely chosen, since the Immigration Service is obliged to denounce the UM to the police.

In **Sweden**, the situation recently (in 2013) changed from an access restricted to the emergency services towards a broader access to primary and secondary care services. The previous Health and Medical Care for Asylum Seekers and Others Act did not cover undocumented migrants, which implies that they had right to emergency care only and moreover the county councils could claim reimbursement for the full cost. The legal reform harmonized the situation between adult undocumented migrants and asylum seekers: both groups have nowadays access to acute care and health care ‘that cannot be postponed’, including maternity care, family planning, termination of pregnancy, dental care and associated medicines, provided that they pay the fee of around €5 per visit. Children have now free access to all types of care services.[76]



Absence of legal framework

In some countries, e.g. Malta, no legal regulations are provided to ensure the access to healthcare for undocumented migrants. Only a non-legally binding policy document describes that all foreigners in detention are entitled to freestate medical care and services. This informal document only refers to free access to healthcare services in closed detention centres, no information is provided on the rights to access health care for UM in open centres of other accommodation facilities. The lack of a clear legal framework, leads to various arbitrary decisions and informal strategies.[30]

Parallel system

In a parallel system, the UM has access to healthcare services if he/she fulfills certain criteria. France is an example of how countries set up parallel administrative systems to ensure access to healthcare for undocumented migrants.[30] This parallel system, State Medical Assistance (AME), allows access free of charge to all types of health services (with the exception of optical products, hearing aids and some dental prosthesis) for undocumented migrants who fulfill some administrative criteria, such as proof of a residence for more than three months, proof of identity and evidence that they remain below a certain income threshold.

Access to current system

In several countries (e.g. the Netherlands) the undocumented migrant has access to the same health services as the nationals. However, in daily practice, this accessibility can be hampered by financial or organisational aspects. [30]

Other types of classification

A slightly different classification is made by the authors of NowHereland in which the countries were grouped in three different categories based on the level of access to healthcare:[77]

- Countries with no access

  This includes countries without entitlements for UM to access healthcare, in consequence the access is restricted to emergency care. Examples of countries with no access to healthcare can be mostly found in Central and Eastern Europe, Scandinavia and the Baltic States. This category can be seen as a clustering from the above-metioned categories "no/restricted access" and "lack of legal framework".

- Countries with partial access

  In these countries the access to healthcare is only guaranteed for specific services and/or specific sub-groups of UM (e.g. children, pregnant women) and/or for a specific diagnosis. Examples of such countries are: Belgium, Italy and the UK.

- Countries with full access

  These countries have the same range of services and entitlements to healthcare for UM and nationals. Examples of crountries are France, the Netherlands, Portugal and Spain (this report dates from before the recent (more restrictive) reforms in Spain). Access to healthcare is tied to a variety of requierements, such as proof of identity, registration in the local civil registry, proof of lack of financial resources and/or minimum duration of stay.

Another classification, made by the European Observatory on Health Systems and Policies[1], identified 5 categories:

- Emergency care: e.g. Austria
- Access beyond emergency, but duty to report: e.g. Germany
- Emergency and (some) primary care: e.g. Spain
- Emergency and secondary care: e.g. Italy
- Emergency, some primary and some secondary care: e.g. Sweden
- Emergency, primary and secondary care: e.g. Belgium

Classification of Belgium

Currently, Belgium can be classified as a parallel administrative system in which the UM has to fulfil several conditions before accessing any healthcare services. Although the definition of UMA could be interpreted as a restrictive access, the UM is entitled to a broad range of curative and preventive care services.

6.3 Regulations abroad as inspiration for Belgium?

The current report aims to optimize the access to healthcare for undocumented migrants, therefore this section focuses only on the countries with a similar procedure as in Belgium, i.e. France, Italy, the Netherlands, Sweden and Portugal.[78] More background information on these countries' systems can be retrieved in the technical sheets per country (see appendix).

Administrative requirements to access healthcare

The current Belgian procedure to obtain access to healthcare is quite complex (see description in previous sections and see Table 7). A logic step would be to simplify this procedure in order to facilitate the access. Two different ways are found in the group of selected countries:

- Direct access to healthcare services without administrative requirements

  Both in the Netherlands and in Sweden, a physician has to approve if the health care is medically necessary and cannot be postponed. After approval the UM can receive medical care, without any further conditions. In both countries no proof of identity is needed.

- Approval on paper based on pre-defined conditions

  Different to the Belgian procedure in which also requirements are defined, this evaluation of the administrative requirements is done on documented evidence (e.g. copy of lease recept, hotel bills). Also the determination of the minimum duration of residence (in France and in Portugal) and the compulsory enrollment in a register (in Italy and in Portugal) are additional criteria compared to Belgium.

As proof that the UM met all the criteria, a medical card is provided (AME in France, STP code in Italy) which will give him/her access to a range of healthcare services, free of charge or at a minimum out-of-pocket payment. The information reported on the medical card can vary: in Italy this card is anonymous, whereas in France personal data and a picture are put on the medical card.

If the undocumented migrant cannot fulfill the above-mentioned criteria, the access to health care can be restricted to emergency care, screening of sexually transmitted diseases and HIV/AIDS, family planning, vaccinations and screening and treatment of tuberculosis.[30]

Feasibility for Belgium

The only condition which is not operative in Belgium is the minimum duration of (uninterrupted) residence in the country.

Whereas in Belgium a lot of time and efforts are used to investigate the administrative conditions, the other countries perform this evaluation on the documented evidence, introduced by the UM.

In the countries with a definition on the kind of care accessible for UM an additional step is required to check if the UM's needs would be covered by this definition. Expanding the access to all healthcare services would make this additional step redundant. The enrollment of the UM in a register (as undocumented resident or as temporary patient) would facilitate monitoring of the patient needs, trajectories of patients through the healthcare system and prevention of infectious diseases.[77]

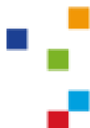


Table 7 – Overview of the administrative conditions to access healthcare services per country

Belgium	The Netherlands	Sweden	Italy	France	Portugal
Social inquiry by CPAS – OCMW: • Under a certain economic threshold • Proof of residence • Proof of identity • UMA certificate delivered by physician	• Decision by physician if medically necessary care is needed	• Decision by physician if medically necessary care is needed • No proof of identity	Proof on paper: • Proof of identity • Enrollment in local administrative district offices or dedicated offices in hospitals • Under a certain economic threshold	Proof on paper: • Proof of identity • Uninterrupted residence >3 months • Under a certain economic threshold (for last 12 months)	For UM residing in P for more than 90 days • Proof of residence (issued by local council) >90 days + submission of 2 witness declarations or a signed statement • Enrollment in habitual residence's health center, i.e. temporary registration as a patient • Proof of lack of economic means

Access to healthcare services

In all countries, the UM has (after fulfilling the administrative requirements) full access to a broad range of healthcare services (see Table 8). Even in the countries with a definition of the accessible care (the Netherlands, Sweden, Italy) the various interpretations of this definition neglect this more restrictive definition. France has set up a list of services which are not accessible for UM (e.g. optical products, care services related to fertility problems). In Italy and in the Netherlands secondary care is only accessible on referral by a GP.

The Netherlands are the only exception where the healthcare services are not free of charge. In the latter the healthcare provider has to prove the inability of the UM to pay. In case of no payment (even after incasso offices), the healthcare provider can be reimbursed by the government. However, this reimbursement is restricted to the healthcare providers and hospitals included in a list. Consequently other healthcare providers and services will be more likely to refuse the care provision to UM.

If the administrative requirements to access healthcare are not met, the access to healthcare services will be restricted to a smaller range of care services (e.g. emergency care, ante and postnatal care). These care services will be still free of charge, other care services will have to be paid at full cost. In Portugal the requirement for the UM to prove insufficient financial means is not only necessary for exemption from co-payments, but for exemption from the full costs of treatment. The UM has to produce documents from public authorities, which many of them will not have, so the access regulated by law is blocked by the administrative procedures in practices.

Feasibility for Belgium

Nevertheless the current system of direct access to all levels of healthcare for the Belgian nationals, a referral system for secondary care could be an option for the UM. No alternative strategies were found in the other countries to facilitate financial accessibility of healthcare. A more restrictive policy is the 5euro measure per pharmaceutical prescription, whereby the UM has to contribute to the pharmaceutical costs. An exception on this measure are the prescriptions for one-week pharmaceuticals.

Table 8 – Overview of the healthcare services per country

Belgium	The Netherlands	Sweden	Italy	France	Portugal
• All types of HC services	• All types of HC services after approval of necessity • Hospitalization only on referral • Payment of full costs by UM, 5 euro co-payment in pharmacies • Reimbursement restricted to list of hospitals and pharmacists under contract (80-100%)	• Care that cannot be postponed, maternal health, abortion care, contraceptive advice, medical examination • Additional HC services possible (regulated by regional authorities) • Free of charge	• Urgent and essential medical care, preventive care, care provided for public health reasons (including prenatal and maternity care, care for children, vaccinations, diagnosis and treatment of infectious diseases) • Registration with GP needed for secondary care • Free of charge	• All types of HC services except optical products, hearing aids and some dental prosthesis, all care services related to fertility problems • Free of charge	• All types of HC services • Free of charge

Duration of the access

The duration of access varied from 6 months to an undetermined period. In France a medical card is delivered for a period of 1year, whereas in Italy the medical card can be renewed after 6 months. However, it is not clear which additional steps are needed for renewal of this card. In other countries, e.g. the Netherlands, the access to healthcare is not restricted in time (see Table 9).

Feasibility for Belgium

The duration of the validity of the medical card could be prolonged to 6 months or 1 year or even for an undetermined period of time to guarantee continuity of care.

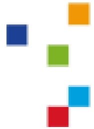


Table 9 – Overview of the duration of access per country

Belgium	The Netherlands	Sweden	Italy	France	Portugal
• Approval for 1year but renewal needed every 3 months	• undetermined	• Not retrieved	• 6 months + renewal	• 1 year + renewal	• Single occasion but renewable

Discussion

Classification of Belgium

The classification of countries with different degrees of access to healthcare remains an artificial exercise. Looking at the current regulations in Belgium, this country can be classified as a country in which legal regulation clearly stipulates which conditions have to be fulfilled to access healthcare. However, if these requirements are not met, the UM will have only have access to healthcare at full charge. This lack of alternatives can be considered as "no access to healthcare system". Dependent from the authors, Belgium is defined as a country with full access to healthcare for UM, or rather as a country with minimum rights, i.e. UM are entitled to emergency care of "immediate" or "urgent" care and/or sometimes a moderate fee is asked.[74, 79] Romero-Ortuno et al, 2004 stated that Belgium has an utilitarian approach of aid for UM, based on the protection of the population of the host country rather than on the basic human rights.[80] Also Hartley Dean stated that in our welfare regime migration and health are framed on the basis of citizenship rather than on universal human rights.[81]

Comparative analysis

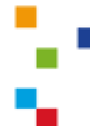
The above analysis of European countries aimed to find solutions for the documented barriers in the current Belgian procedure for urgent medical aid for undocumented migrants. Possible alternatives for the current situation were extracted from the healthcare systems from abroad. In this extraction exercise, these initiatives were disconnected from the country-specific characteristics, like the kind of funding scheme behind each healthcare system (i.e. system of funding by taxation, social insurance or a combination of the two), comparison with the legal entitlements of the nationals etc. Also the description of healthcare systems in the different countries is often restricted to a description of the legislative context by listing up the different entitlements, but the actual practice in accessing healthcare services is missing due to only some public available data on the actual use and provision of care to UM.[77]

Although all EU Member States have ratified several international conventions on the human rights, which ensure access to healthcare for all people without discrimination, other concerns may lead to austerity programmes restricting the access[1]. These concerns are related to the potential magnet effect, i.e. the provision of healthcare would attract more migrants (see section 0). Another concern is the free-rider concern, i.e. the migrant should not benefit from a system for which others have paid. In practice, the UM contribute to the system, by contributing to the economy through taxes on goods and services. A third concern is related to the access to the healthcare system for the nationals, i.e. providing access to UM would reduce access for others and would increase the costs. Nevertheless the scarce evidence on the costs related to the acces to healthcare services for UM, it could be estimated that a lack of primary and preventive care could lead to much higher costs by using other levels of care services (e.g. emergency care departments in hospitals).

The comparison between countries revealed different approaches to ensure access to healthcare, such as:

- Allowing UM to purchase insurance coverage in the national system(e.g. Switzerland)
- Automatic coverage in the national health system (e.g. Portugal)
- Providing an additional source of funding to assure that physicians and hospitals receive compensation for their provision of services (e.g. the Netherlands)

Until a country has implemented a policy which facilitates the access to health care for UM, other initiatives will continue to meet the needs of the



UM (e.g. interim solutions by care providers, voluntary and charity organisations, local and regional authorities).

Evaluation of the current procedures

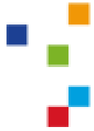
The above-mentioned possible strategies for Belgium, based on the comparison with 5 countries, should be interpreted with caution. The information is derived from legislative sources, not taking into account the current implementation of these regulations. Administrative requirements to be fulfilled can in reality be more complex due to different factors (e.g. attitude of healthcare providers, language and cultural barriers, etc). For a reliable analysis of the feasibility of other organizational strategies for Belgium, quantitative and qualitative data is needed on the actual implementation of these strategies in the country of origin.

During the search for information per country, evaluation reports on the actual use of healthcare services by UM were found for the Netherlands and for France.

In the most recent report of the Dutch National Health Institute on the governmental costs related to healthcare for undocumented migrants, an evolution in costs per type of care service is presented.[82] In summary it could be stated that an increase with 3.5% is noticed between 2013 and 2014 for the total of costs. This increase is mainly due to the higher increase in the mental health care services (increase with 80.3%) and due to the reforms in the data registration in the hospitals which leads to a delayed transfer of costs. In primary care the increase is mainly due to the increase in costs for dental care and maternal care. Nevertheless the potential financial barrier of the 5 euro measure in pharmacies, no decrease in delivered pharmaceuticals was noticed. In 80% the UM paid this out-of-pocket payment, whereas in the remaining 20% these fees were paid by a third party.

Although France aims to guarantee a universal access for all minority groups (including the UM), the report from the Defender of Rights (an independent administrative authority in France) evaluated the possible reasons (and solutions) for renouncement of care in these minority groups.[83] Since no data is available on the total number of UM due to their illegal status, also the proportion of UM who do not benefit from the AME is unknown. Refusal of care is often reported in UM without AME-status, i.e. UM who did not apply for this procedure or who do not fulfill the conditions. However, these persons have still the right to access emergency care, but this regulation is less known by the healthcare providers. This lack of knowledge of the current procedures is also due to the constant changing regulations. For example, whereas in 2000 a declaration on honor was sufficient to proof the identity, residence and financial resources, now the conditions are more complex and written pieces of evidence have to be shown. This additional step in the procedure induces variety between the local offices of the health insurance (‘caisse primaire d’Assurance Maladie’). Currently the medical card is valid for one year. If a renewal is needed, the procedure should already be started 2 months in advance. Data from 2007 show that less than 40% renew their medical card every year. Other factors hampering the access to health care are discussed in the report (such as type of healthcare provider, regional differences, attitudes of the care professionals) but this discussion is out-of-scope for this section of the report.

Concerning the budgetary aspects related to AME, an overall increase in costs is noticed since the implementation (in 2000) and even an accelerated increase over the last three years (see Figure 13). Figure 13 shows an average annual increase of 27.5% in 2000-2004, 24.5% in 2005-2007 and 18.9% in 2007-2010, i.e. the budget increased from 138,8 million euro in 2002 to 588 million euro in 2011.[84] An explanation for this evolution in costs is the underestimation of the initial budgets to cover all costs related to AME, so several rectifying financial regulations were needed (e.g. in 2002 61 million euro was provided but an additional amount of 445 million euro was needed to cover the costs of 2002 and to cover the debts from 2002 onwards). Further evaluation of the costs revealed also that the largest part of the total costs is related to hospital care (in proportion to a small number of UM) and costs are related to geographical concentration (e.g. higher costs in Paris). Three possible reasons for the increase in costs could not be proven in the data-analysis, notably:



- an increased number of AME per UM due to the legal entitlement of one AME to several persons in the same household: no significant change over time is seen in number of AME per UM (in 81% 1 AME per person, in 13% 1 AME for more than 1 person)
- an “explosion” in average consumption of health care services: no significant differences were found with the persons covered by the national health insurance
- fraud: the number of fraudulant cases related to AME is 0.2 to 0.3% of the total number. Another identity could be used by the UM to claim AME, but the frequency of this kind of fraud is reduced by the introduction of secured cards. Evaluation by audits showed that the other administrative requirements for AME (i.e. proof of uninterrupted residence and lack of financial resources) were not related to fraud. Some fraudulent cases among the healthcare providers were noticed, but this small number could not explain the increase in costs.

Main reasons for the increase in costs are related to the invoice policy by the hospitals, notably

- a more efficient search for health insurance coverage for their patients
- a tarification per diem (instead of per activity, which is compulsory for the insured persons): this rate, which covered in the past all hospital costs, has not been reduced after the introduction of a lump sum financing per activity.

Based on this evaluation, the authors recommend to sustain the current AME procedure and to keep this procedure out of the national health insurance. Within the AME more preventive measures should be available for the UMA, e.g. a compulsory consultation with the GP for a general health check. The main reason for the increased costs, i.e. financing policies in hospitals, should be tackled by introducing the same financial mechanisms as for insured persons. Next to these policy measures, data collection is needed to further modify the legal regulations to the medical needs of the UM.

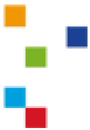
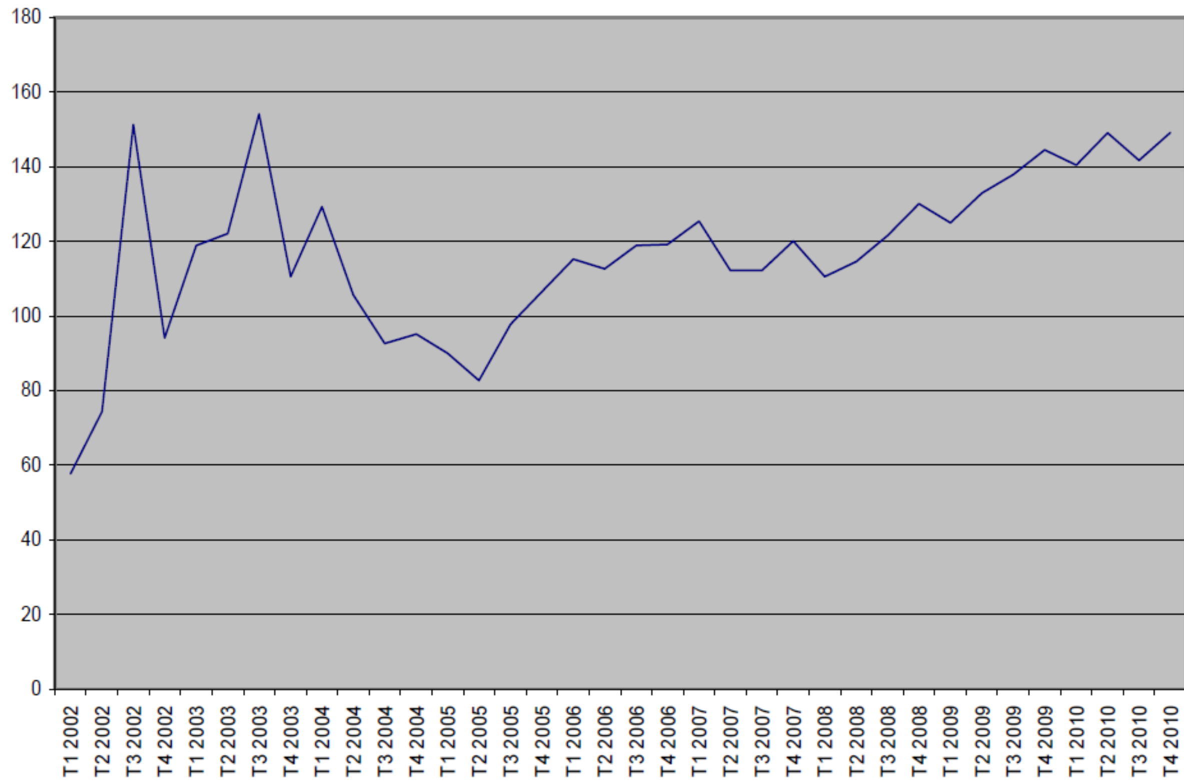
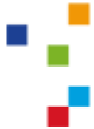


Figure 13 – Evolution over time (2002-2010) of the expenses related to AME in France



Source: Goasguen et al, 2011[84]



7 RECOMMENDATIONS FOR A REFORM OF UMA

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

We propose a reform of UMA to alleviate as much as possible these difficulties and to reach a more favorable equilibrium between the right for all to access health care and a rational utilization of public resources. The reform follows two main lines: simplify and harmonize administrative procedures; rationalize access to health care. The various elements of the reform were elaborated to address the difficulties and weaknesses evidenced by our research. These elements are derived from our situation analysis, the experience and the views of interviewees, good practice observed in some CPAS – OCMW, and examples from abroad. They take into account as much as possible the current legal framework. All the elements of the reform were discussed with stakeholders and key decision-makers (see colophon), and their views and suggestions were incorporated in this final version. These elements form a whole and must not be considered in isolation. They are summarized in table 10. They constitute the basis for reflection and discussion of the main decision-makers in view of improving UMA.

It is quite impossible to accurately forecast today the cost of the proposed reform. On the one hand, the facilitated procedures may hopefully result in a better coverage and increase costs. On the other hand, complex pathologies needing hospitalization because of delayed care should decrease. Costs related to administrative tasks should also decrease. Two recent studies go in that direction[10, 22]. Whatsoever, the reform needs to be closely monitored. Any inappropriate use of resources should be detected early and amended.

7.1 Facilitating the demand for medical aid

The UM are encouraged to apply for medical aid to the CPAS – OCMW of his/her municipality of residence outside of any disease episode. A medical certificate of UMA is not required anymore. This will allow avoiding delays in health care when a disease episode occurs, reducing the number of UM going directly to hospital in case of disease, and treating diseases before they become more serious with an impact on treatment costs. This will also allow delivering preventive care, including in mental health, in line with the content of the 1996 Royal Decree[6]. To avoid any confusion about the care package available, the name of UMA must be changed, e.g. it should be called “Health coverage for undocumented migrants” or “Temporary health coverage”.

7.2 Streamlining the social enquiry

7.2.1 Health coverage during the social enquiry

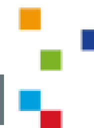
As soon as the application for medical aid is introduced, the applicant receives a medical card which initial validity is one month (see section 7.4). The possible health care needed during the social enquiry are covered. During this period, only the primary health care are accessible, except in case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

7.2.2 Streamlined social enquiry

7.2.2.1 Reevaluate the place of resource assessment

Today, the information gathered on the applicant resources serves essentially to decide if the SPP IS – POD MI will cover the co-payment for health care delivered outside the hospital setting[33], which represents little money in the overall UMA budget. Therefore we propose to collect information on the applicant’s resources only if the applicant declare to being able to pay the co-payment.

The definition of indigence is harmonized among CPAS – OCMW (e.g. defined as resources below the minimum welfare salary). To have resources beyond the indigence threshold cannot not constitute a reason to refuse UMA but only a reason to refuse the coverage of the co-payment. The impossibility to assess accurately the resources of the applicant (e.g. in case of undeclared work) cannot be a reason to refuse UMA.



7.2.2.2 The home visit becomes optional

The SPP IS – POD specifies that "when the demand concerns the coverage of health care, the CPAS – OCMW will evaluate the necessity and the added-value of making a home visit" [34]. Subsequently, the absence of home visit cannot be a reason for UMA refusal as far as the reasons of this absence are explained transparently (e.g. homeless UM). If the UMA applicant is homeless, the CPAS – OCMW where he/she applies is de facto considered competent to manage that application.

7.2.2.3 The social enquiry is integrated in MediPrima

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

7.3 Standardizing the medical card.

The initial validity of the medical card is one month (see point 7.2.1). The medical card is extended to one year if no obvious elements of fraud are detected during the social enquiry, i.e. elements obviously contradicting the contents of the information previously provided by the applicant. If fraud is suspected, an in-depth social enquiry is started of which the results are presented to Council of Social Action of the CPAS – OCMW to decide on the cancellation of the medical card, without any retroactive effect.
The medical card is standard for all CPAS – OCMW. The medical card is individualized. It is established on the basis of an original identity document, it mentions the name, surname, and number NISS of the bearer, and a photo of the bearer is reliably stapled on it. The name of the applicant's children with age<18 years are also reported. It also mentions the name and the INAMI – RIZIV number of the general practitioner holding the Global Medical File (GMF) of the UM. Lastly, the medical card also mentions if the copayments are covered and the MediPrima number of the applicant.
If the UM presents at the emergency department of the hospital without a medical card, a medical card with a limited duration (1 week) is created and care is delivered. The UM must go to the CPAS – OCMW of his/her municipality to get a standard medical card afterwards. If the UM is hospitalized after going through the emergency department, a social assistant (CPAS – OCMW or the hospital) will arrange the medical card during the hospitalization (see point 7.1.2). It is recommended that hospitals managing high numbers of UMA are equipped with a 24 hour-a-day social service to do the social enquiry (see section 7.2.2).
If the UM presents at another level of the health system (GP, dentist, specialized medical doctors) without a medical card and there is no medical emergency, the UM will be sent first to the CPAS – OCMW to arrange a medical card.

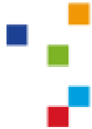
7.4 Harmonizing health care which are covered

The medical card gives the same entitlement to health care to any beneficiary. The CPAS – OCMW is no longer involved in defining the entitlement to health care. The coverage is the same for all UM and the same as for asylum-seekers as defined in the Royal Decree of 09 Aprill 2007[85]. The list encompasses all the health care of the INAMI – RIZIV nomenclature with 5 notable exceptions: examination for and treatment of infertility; aesthetic surgery except reconstructive surgery after surgery or trauma; orthodontics; false teeth in the absence of mastication problem; dental care and tooth extraction under general anaesthetic.

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

For UM with insufficient resources, some care usually not reimbursable within the INAMI – RIZIV nomenclature will also be covered, as defined in the Royal Decree for asylum-seekers[85]: drugs on the D list prescribed by a medical doctor (except treatment for sexual impotence), provided that the generic brand is prescribed and the reference reimbursement price is applied; drugs of the D list not prescribed by a doctor (antacids, spasmolytics, antiemetics, antidiarrheics, analgesics, antipyretics, drugs for affection of the mouth and pharynx), provided that the price of the cheaper product is applied; tooth extraction; false teeth only in case of mastication problem; simple (no bi-focal or multifocal or tinted) glasses prescribed by an ophthalmologist to children and adults if the latter have a deficiency of at least 1 diopter; milk for infant if breast-feeding is impossible).

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



7.5 Rationalizing the utilization of health care

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

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

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

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

7.6 Simplifying the financing

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

7.7 Ensuring continuity of care and information

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

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

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

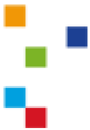
The rapid extension of MediPrima to primary care will be an asset to ensure the continuity of the information.

7.8 Improving communication

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

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

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



7.9 Enhancing monitoring and evaluation

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

- The CPAS – OCMW can encode every application for medical aid in MediPrima, as well as the results of the social enquiry.
- A field for UMA must be created for minimal hospital summary (RHM) so that the morbidity profile of UM can be monitored as for any other patients.
- MediPrima must be rapidly extended to primary health care to allow an overview of health care practice and costs. Meanwhile, providers of primary health care will send their certificate for health care provided.
- The claim data of the CAAMI – HZIV should be integrated in the INAMI – RIZIV dataset and be analysed in the same way, i.e. feedback to prescribers, identification of potential under-utilization or over-utilization of health care, detection of outliers, field inspections. In the future, it would be possible to draw a picture of the hospital care delivered to UM provided that a separate insurability status code is created, as this was also the case for other foreigners a few years ago[ccc][37].

[ccc] Following the 2011 KCE recommendations33, the registration of the aggregated hospital claims data concerning foreign patients falling under categories 300 (care contracts), 310 (private initiative), 320 (patients attached to an international or European institution) and 330 (non-European patients not falling under international conventions), was made mandatory from MZG – RHM registration year 2013. This simplified registration encompasses the hospital day or admission lump sums, the drugs reimbursements (by product) and the procedures reimbursements (by procedure). It is not clear if non-European undocumented migrants could be considered under code 330 or if they are not included in this aggregated registration, as falling under code 400 (Not insured).

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

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

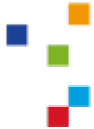


Table 10 – Main elements of the reform of medical aid

	Reform
Simplifying social enquiry	1. An enquiry on resources of the applicant becomes optional 2. The home visit becomes optional 3. A certificate of UMA is no longer necessary
Harmonizing health care covered	1. The CPAS – OCMW delivers an individualized medical card valid one month when to the applicant; primary health care are covered during social enquiry 2. The medical card is extended to one year if the social enquiry is conclusive, and can be renewed 3. The medical card can be delivered in the absence of disease episode 4. The entitlement to health care is unique and corresponds to the entitlements for asylum seekers (as defined by RD 2007)[85]
Rationalizing health care	1. The Global Medical File is compulsory 2. The choice of the practitioner is free but access to specialized care is possible only with a request from GP 3. A priori and a posteriori INAMI –RIZIV rules are applied
Improving communication	1. UMA is renamed “Health coverage for UM” or “Temporary health coverage” 2. Competencies and support to field actors in matter of intercultural communication must be improved 3. A common roadmap describing accurately the procedures and the mission of every actors must be elaborated 4. In case of conflict, parties can seek advice of an independent mediator
Ensuring monitoring	1. The results of the social enquiries are available in MediPrima 2. A data field is created in the RHM - MZG to identify beneficiaries of medical aid 3. MedPrima is rapidly extended to the primary care 4. CAAMI-HZIV data relating to medical aid to UM must be transmitted to INAMI and analysed

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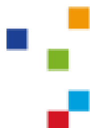

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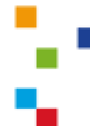

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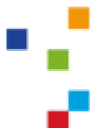

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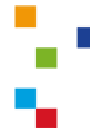

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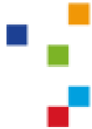

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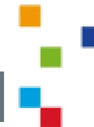


■ APPENDICES

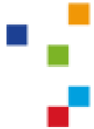
APPENDIX 1. FORM TO COLLECT INFORMATION IN CPAS – OCMW

Administratieve gegevens

1	Datum	
2	Gemeente/stad	
3	Staff OCMW (naam + functie)	
4	Staff KCE	
5	Datum verslag verstuurd naar staff OCMW	
6	Datum goedkeuring verslag door staff OCMW	

Algemeen beeld van DMH

1	Algemeen parcours van een DMH-aanvrager	
2	Criteria en methode om territorialiteit te bepalen*	
3	Criteria en methode om illegaliteit te bepalen	
4	Criteria en methode om behoeftigheidstatus te bepalen *	
5	Criteria en methode om dringendheid te bepalen*	
6	Andere criteria voor verkrijgen van DMH*	
7	Duur geldigheid DMH	



8	Type van zorg gedekt door DMH	
9	Type van zorg buiten nomeclatuurcode RIZIV	
10	Samenwerking met zorgverleners? Aan welke voorwaarden?	
11	Gebruik van Mediprima?	
12	Controle-arts? Welke functie?	
13	Frequentie van huisbezoeken?	
14	Andere controle-mechanismen?	

Statistieken

1	Aantal aanvragen/jaar	
2	Voornaamste nationaliteiten van aanvragers	
3	Aantal DMH/jaar	
4	Hoofdredenen voor weigering	
5	Statistieken DMH voorhanden?*	
6	Aantal VTE voor DMH?*	
7	Budget voor DMH (buiten de terugbetaalde ziektekosten)	

Perspectieven

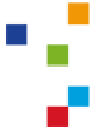
1	Problemen	
2	Visie op mogelijke oplossingen	
3	Andere opmerkingen	

APPENDIX 2. INSURABILITY STATUS IN MZG – RHM AND FINHOSTA.

Table 11 – Insurability status from year registration 2012

Code	Sickness Funds or other (Fr)	Sickness Funds or other (Nl)
001	Union nationale des mutualités chrétiennes	Landsbond der Christelijke Mutualiteiten
002	Union nationale des mutualités neutres	Landsbond van de Neutrale Ziekenfondsen
003	Union nationale des mutualités socialistes	Nationaal Verbond van Socialistische Mutualiteiten
004	Union nationale des mutualités libérales	Landsbond van Liberale Mutualiteiten
005	Union nationale des mutualités libres	Landsbond van de Onafhankelijke Ziekenfondsen
006	Caisse auxiliaire d’assurance maladie-invalidité (CAAMI)	Hulpkas voor Ziekte- en Invaliditeitsverzekering (HZIV)
009	Caisse des soins de santé de la SNCB	Kas der geneeskundige verzorging van de NMBS
200	Institut national des invalides de guerre, anciens combattants et victimes de guerre	Nationaal Instituut voor Oorlogsinvaliden, Oud-strijders en Oorlogsslachtoffers
210	Caisse de secours et de prévoyance en faveur des marins	Hulp- en Voorzorgskas voor Zeevarenden
220	Office de sécurité sociale d’outre-mer	Dienst voor Overzeese Sociale Zekerheid
230	CPAS – OCMW	OCMW
300	Contrats de soins	Zorgcontracten van niet-Belgen
310	Initiative privée	Privé-initiatief van niet-Belgen
320	Attaché à une institution de droit international ou européen	Aangeslotenen bij een instelling van internationaal of Europees recht
330	Patients non européens ne relevant pas de conventions internationales	Niet-Europese patiënten die niet vallen onder internationale overeenkomsten
400	Non assurés	Niet-verzekerden
500	Autres	Andere

(A2_CODE_STAT_INSURANCE in RHM – MZG and item_01 in Finhosta)



APPENDIX 3. INTERVIEW GUIDE FOR UNDOCUMENTED MIGRANTS

Part 1: General presentation of the project

Good morning/afternoon/evening Madam/Sir/Miss … (name) I am … and I work for the Ghent University/ Université catholique de Louvain. As we have discussed before, you were informed that we – together with the Université catholique de Louvain/Ghent University – conduct research on the procedures of urgent medical aid. You have agreed to meet us and to share your experiences with us. We are most grateful to you for this.

We would first like to ask you some questions about yourself, and after that we would like to ask you about your experience with the urgent medical aid procedures. We would also like to know how these procedures could be improved according to you. Of course all information will remain anonymous and we won't share your data with anybody. Your participation in this research project has no effect on your current situation, your procedure or right to health care. Because we cannot write the whole time while you are talking, we would like to record our conversation. Is this all right for you? You can also decide at any moment during the interview to stop without giving an explanation.

Do you have further questions?

Is it all right with you that we start the interview now?

Part 2: Socio-demographic data

1. Gender
   - ☐ Female
   - ☐ Male
   - ☐ Transgender

2. In which year were you born?
   - ☐ _ _ _ _
   - ☐ Unknown

3. What is your family situation?
   - ☐ Single
   - ☐ Cohabits with partner or family
4. If you have a partner or family, do they live in Belgium too?
   - ☐ Yes
     - o We live together at the same place
     - o Partner/family lives somewhere else
   - ☐ No
5. Do you have children?
   - ☐ Yes
     - o How many? _ _ _ _
   - ☐ No
6. If you have children, do they live together with you?
   - ☐ Yes
     - o We live together at the same place
     - o Child(ren) live(s) somewhere else
   - ☐ No
7. Do you live together with other children (other than your partner and own children, e.g. parents, other family members)? Could you tell us more about this?
   - ☐ Yes
     - o With whom? _ _ _ _
     - o How do you feel about this? _ _ _ _
   - ☐ No

8. In which country were you born? _ _ _ _

9. How would you describe your ethnicity? *(The same as the majority of the population of … thus…or rather…?)* _ _ _ _

10. Since when do you live in Belgium?
    - ☐ Less than 2 years
    - ☐ 2 to 5 years
    - ☐ More than 5 years

11. What were your daily activities in your country of origin? _ _ _ _

12. What are your daily activities in Belgium? _ _ _ _

13. How would you describe your housing situation?
    - ☐ No fixed domicile address
    - ☐ Emergency shelter or precarious housing
    - ☐ Therapeutic or medical institution with 24/24 care
    - ☐ Institution
    - ☐ I live together with different people (friends, family…)
    - ☐ I live alone
    - ☐ Structure for asylum support (local refugee initiatives, asylum centre…)
    - ☐ Other…

14. How would you describe your health status?
    - ☐ Very good
    - ☐ Good
    - ☐ Neither good nor bad
    - ☐ Bad
    - ☐ Very bad

Part 3: General situation

15. Our research deals with health, and therefore also with being ill. Have you been ill since you live in Belgium (or someone from your family or friends)?
16. What do you generally do when you fall ill?
17. In that case, with which barriers or problems are you confronted?

Part 4: Urgent medical care

In our study we evaluate the current procedure of urgent medical care based on the experiences of patients. Therefore we would appreciate if you could tell us more about your experience. If you prefer to tell the experience of someone else who is close to you and who you know well, that is fine too.

18. How did it work when you (or another person/friend/x) was ill and had to seek urgent medical care? *Could you describe that? What did you do first? What worked smoothly? Which problems were you confronted with?*
19. Is there anyone among your friends, family or acquaintances who has been denied urgent medical care? *If so, can you explain to us why that help was refused according to you? Do you think we could contact that person for an interview? Yes so, in what way? Can you bring us in contact? Or...?*

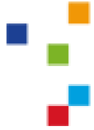
Part 5: Accessibility to procedure of urgent medical care

I also would like to ask you some specific questions about your experience with the procedure. Is that all right?

20. When you needed a doctor (a general practitioner), how did you find out where you could find one? *Did you get an explanation from someone, did someone give you a specific name? Who was the person who explained this to you or who gave you a name gave? How have you dealt with that?*
21. When you – still within that procedure - , had to look for medication, how did you manage to do that?
22. When you had to consult a specialist (for a specific problem: mental health, gynaecology, cardiology, respiratory medicine ...), how have you handled it?
23. Were there certain issues or problems that implied that you could not be cared for? (e.g. dentist) Could you describe that?
24. Have you ever experienced that the care you needed or wished to have was refused to you? If so, for which specific health problem?
25. Could you tell us a little more about how your contacts/experiences with the Belgian doctors and nurses generally went? *What have you appreciated about them? What did disturb you? Could you explain that?*

Part 6: Solutions

26. According to you, how could the Belgian government make it easier to obtain health care for undocumented migrants? (*What could be done to make it easier to have urgent medical care allowed to somebody (procedure), and if you are allowed urgent medical care how could the access to health care be improved according to you?)*



Part 7: Conclusion

27. For me you have answered all my questions, but is there anything else you would like to clarify or complete? Is there anything else that matters and which we have not mentioned yet?
28. Do you have other questions?
29. Would you like to receive information about the research project? Would you like to be kept informed of the results of our research? *(if so, how, how should we contact you?)*
30. Would you like to get information on health or place you could be referred to? *(answer or refer)*

I want to thank you very much for the time you have taken for me and to answer all my questions. As a small reward I am happy to give you this voucher. As you know, you can always contact us, our details are on the information form.

APPENDIX 4. INFORMED CONSENT FOR UNDOCUMENTED MIGRANTS

Research on urgent medical aid (part 1: for respondent)

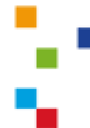
We would like you to participate in a research project that aims at providing an in-depth analysis of the current practice of Urgent Medical Aid (UMA) for Undocumented Migrants (UM) in Belgium. In this research that is led by the University of Ghent and the Université catholique de Louvain, we would like to identify what the strengths, weaknesses, opportunities and threats are of the current procedures granting undocumented migrants access to health care.

To this end we will interview undocumented migrants in Brussels, Flanders, and Wallonia as well as health care professionals and organisations assisting undocumented migrants in getting health care. Based on these interviews we will write a report indicating what goes wrong and how the situation could be improved. This report will be handed over to Belgian Health Care Knowledge Centre who has given us the duty to conduct this research. They will then discuss the recommendations with the Belgian government.

We thus invite you to an IN-DEPTH INTERVIEW that will take about an hour to an hour and a half. This interview is completely confidential and takes place at a place where you feel safe and can speak freely. It will be conducted in a language that you master well and is commonly agreed upon with the interviewer. If necessary, this involves an interpreter. You can stop the interview at any moment without having to provide us with a reason why you would like to stop.

This interview will not cause you any harm. If in the course or at the end of the interview, you feel in need of health care, social or judicial assistance, we can refer you to organisations or health care settings that can meet those needs. This interview will not affect your legal status or any procedure nor will it directly change your right to health care.

We guarantee anonymity. In order to take everything into account what you mention, we would like to record the interview. Your name will however not be mentioned on this tape and only the researchers will listen to it. After the end of the project, the tapes will be destroyed. We will only ask to sign this



informed consent form which will be kept separately from your interview and which will only be accessible to the principle researchers. All the information given in the interview will be analysed and stored anonymously. Your name will not be communicated to anyone beyond the team of researchers, unless you would want it too.

At the end of the project we can inform you of the results either through a written report or a short phone conversation. You can contact the principle researchers at any time through mail: ilse.derluyn@ugent.be, ines.keygnaert@ugent.be, Birgit.kerstens@antwerpen.be, Tel 09/264.62.85 and marie.dauvrin@uclouvain.be, Tel 02/7643471.

Research on urgent medical aid (part 2: for researcher)

By signed this form you confirm that:

1. An explanation of the nature of the research has been offered and is understood.
2. The doubts you had have been solved.
3. You are participating voluntarily
4. You give the permission to the researchers to save and report the results anonymously
5. You are aware that you can quit the interview at any time without consequences
6. You are aware that you can be informed on the results at the end of the project.

Read, understood and approved on ______________________

Name ________________________________

Signature ______________________

Name: ____

(Optional: contact details for communicating on end results (tel/e-mail/own address or that of a friend/organisation…)
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APPENDIX 5. GUIDE FOR FOCUS GROUPS

Key 1 - (Inter) Personal level of provider-patient

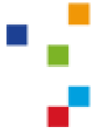
1. *Transition:* Can you present yourself quickly providing your name, your function, your health facility and how you are related to the issue of urgent medical care? (round of the table)

2. *Key:* How would you define urgent medical care?

3. *Clinical vignette (inter)personal level:*
   3. A) for hospitals: Mister LA, HIV positive and with anal cancer in a very progressive state did not get a medical card for UMA in one city because "this can be treated in his home country as well and treatment is not necessarily urgent" while in another city, he got the card immediately as the oncologist urged the CPAS – OCMW to get the necessary paper work quickly done and convinced the hospital board to start chemo and radiotherapy within a week upon several surgeries given the prognosis.
   - What do you think of this case? And of the "demarche" of the oncologist?
   - How would you go about this case if this patient would administer at your health facility?

   (If respondents start to elaborate on the CPAS – OCMW involvement of defining urgent medical care, probe first for the personal aspects and then move on to the following question indicating that you will come back to this issue)

   3. B) for GPs: The CPAS – OCMW has granted the medical care to the family G, letting them the liberty to choose their GP in their neighbourhood. Yet, several local GPs refuse to provide care to the family G, finally family G has decided to consult a medical facility in the closest large urban centre, which is at one-hour distance by public transportation.
   - What do you think of this case?
   - How would you go about this case if this patient would administer at your health facility?



Key 2 - Organisational level at health facility

4. *Transition:* When undocumented migrants present themselves at your health facility what is the regular procedure for providing them care?

5. *Key: W*hich aspects do you consider as strong points in how your health facility provides care to undocumented migrants?

6. *Key:* Which challenges do you consider as most difficult to overcome in your health facility when wanting to provide urgent medical care to undocumented migrants in your health facility?

7. *Clinical vignettes organisational level:*
   7. A) Mister & Mrs M are here since several years, he needs haemodialysis at least twice a week. They got their 9-ter (medical grounds) stay denounced a few weeks back. Miss M devotes her life to the health of her husband, so does the hospital, the general practitioner, and the supporting organisations. Yet, Mrs M suffers from a growing cyst in her left breast since more than 15 months with pain in her breast, shoulder and upper left arm since more than 4 months. Nobody ever asked how she was doing, so she did not dare to tell.
   - How would you go about this case when this couple would administer at your health facility?
   - Probe for limits and opportunities in treating persons in a systemic way.

Key 3 - Exo level: local political/legal level

8. *Transition:* do you believe that health facilities have sufficient freedom to decide how to provide care to undocumented migrants? Should you have more freedom? Please elaborate

9. *Administrative level- financial reimbursement: decision of CPAS – OCMW of what is urgent medical care and what should be reimbursed.*

Regarding the CPAS – OCMWs you are working with, how would you evaluate the following cases?

Clinical vignettes: (*at least A or B, if time enough also C)*
9. A) Mrs V has a little boy of 8 years old, suffering from epilepsy. For his treatment, the neurologist recommended a serial of additional examinations at the hospital. The CPAS – OCMW has refused a financial intervention for the examinations but reimburses the consultation in neurology.

- Could you imagine this happening at your health facility and region? How would you go about this case?

9. B) Mr C has a type 2 diabetes, with complications (retinopathy and diabetic foot). His GP asks him to check his glycaemia four times a day. The CPAS – OCMW gives a reimbursement for two checks per day only.

- Could you imagine this happening at your health facility and region? How would you go about this case?

9. C) Mrs N had the orange card and, in this context, received an orthodontic treatment. After the annulation of the orange card, the CPAS – OCMW informed that it was not able to take into the fees related to the treatment. Consequently, Mrs N has had to remove her orthodontic apparatus.

- Could you imagine this happening at your health facility and region? How would you go about this case?

Key 4 - Societal level

10. *Transition:* We now would like to evaluate procedures installed by the government: which of the following do you believe to support you or rather hamper you in providing care to undocumented migrants?

10.1: Administrative level- list of treatments to be reimbursed: Regarding the list of treatments to reimburse: how would you go about the following case(s) if this patient would administer at your health facility?

Clinical vignettes:

10.1. A) Miss B was raped in her home country and turned out to be HIV positive as a result of the rape. Being pregnant for the second time, but now undocumented as her asylum request got rejected, she wonders how she will manage to pay for the powder milk of the newborn.

10.1. B) Mrs N had the orange card and, in this context, received an orthodontic treatment. After the annulation of the orange card, the CPAS – OCMW informed that it was not able to take into the fees related to the treatment. Consequently, Mrs N has had to remove her orthodontic apparatus.

10.2: Administrative level: CPAS – OCMW checking the migrants' address: How do you feel about the following case of the CPAS – OCMW checking addresses? Is this something you have come across with the CPAS – OCMW in your region?

Clinical vignette:

10.2. A) Miss E, 8 months pregnant, went to CPAS – OCMW for urgent medical care. She stays consecutively at 2 places: one of a single female friend and another of a couple of friends' apartment. CPAS – OCMW is accusing her of being unable to become a decent parent as she does not dare to disclose the location of the friends' places and thus cannot get the UMA. As the CPAS – OCMW assistant tells her they will bring the police along, she is afraid to tell where she is staying. As a consequence, they refuse to give her the medical card.

11. *Key:* which other challenges related to the Belgian policy about urgent medical care do you consider as rather straining the ways in which you can provide care to undocumented migrants?

CLOSE: Key 5 - All levels

12. *Key:* if you could change the procedure for UMA, how would you go about improving it?

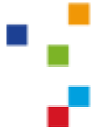
APPENDIX 6. INFORMED CONSENT FOR HEALTH CARE PROFESSIONALS AND HEALTH CARE MANAGERS

We would like you to participate in a research project that aims at providing an in-depth analysis of the current practice of Urgent Medical Aid (UMA) for Undocumented Migants (UM) in Belgium. In this research that is led by the University of Ghent and the Université catholique de Louvain , we would like to identify what the strengths, weaknesses, opportunities and threats are of the current procedures granting undocumented migrants access to health care.

To this end we will interview undocumented migrants in Brussels, Flanders and Wallonia as well as health care professionals and organisations assisting undocumented migrants in getting health care. Based on these interviews we will write a report indicating what goes wrong and how the situation could be improved. This report will be handed over to Belgian Health Care Knowledge Centre who has given us the duty to conduct this research. They will then discuss the recommendations with the Belgian government.

We thus invite you to a FOCUS GROUP DISCUSSION that will take about an hour and a half. This focus group will be conducted with other professionals similar to your function, who are also providing care or assistance to undocumented migrants in the same region as you are (Flanders, Brussels or Wallonia). The focus group takes place at a place that can easily be reached from your work setting at an hour that was perceived as convenient to the participants. You can quit the focus group at any moment without having to provide us with a reason why you would like to stop.

This focus group will not cause you any harm. We will only ask to sign this informed consent form which will be kept separately from the other data gained through the focus groups and which will only be accessible to the principle researchers. All the information given in the focus group will be analysed and stored anonymously. Your name will not be communicated to anyone beyond the team of researchers, unless you would want it too. Apart from your transport costs to the focus group, no other incentives will be given.

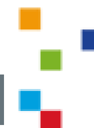


At the end of the project we can inform you on the results either through a written report or a short phone conversation. You can contact the principle researchers at any time through mail: ilse.derluyn@ugent.be, ines.keygnaert@ugent.be, Birgit.kerstens@antwerpen.be, Tel 09/264.62.85 and marie.dauvrin@uclouvain.be, Tel 02/764 34 71.

By signed this form you confirm that:

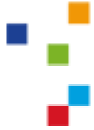
1. An explanation of the nature of the research has been offered and is understood.
2. The doubts you had have been solved.
3. You are participating voluntarily
4. You give the permission to the researchers to save and report the results anonymously
5. You are aware that you can quit the interview at any time without consequences
6. You are aware that you can be informed on the results at the end of the project.

Read and approved on ______________________
Signature________________________________



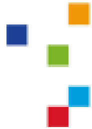
APPENDIX 7. SWOT ANALYSIS BASED ON INPUTS FROM KEY INFORMANTS

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
A. LEGAL AND POLITICAL FRAMEWORK AND PROCEDURES			
A1. Right/entitlement of undocumented migrants to be granted urgent medical aid			
*** "UMA is a right, not a favour" which increases the accessibility to the services available to UM and the opportunity of a dignified life** *** Strong legal basis of UMA (as compared to other European countries) which contributes to proper diagnosis and treatment (and therefore to public health)** *** UMA emphasizes the use of the regular health care system (no target group-specific medicine)** *** UMA legislation has few barriers to entry**	* Unfamiliarity of the right/system (in some populations) implies that not all undocumented migrants activate their right even when being entitled to * Exclusion from UMA or difficulty with practical application of UMA for some persons, e.g. economically inactive European citizens, homeless people who cannot demonstrate that they stay on the CPAS – OCMW territory * The right to urgent medical aid for undocumented migrants is activated in an unequal way by different organisations (and has impact on CPAS – OCMW)	* Universality of the right gives chance to undocumented migrants to activate the right to urgent medical aid * Possibility to claim the right to UMA offers opportunity of dignified and safe life	* Non-respect of international conventions * Possible influence of neighbouring countries with limited right to UMA * Confusion with 'new' UMA for citizens from European Union * Abuse of the right to urgent medical aid by (some) individuals could lower public and political support
*** UMA is legally enforceable** *** Fact that UMA is embedded in the federal law results in less regional differences** *** Relatively few conditions in the law to comply with right to UMA: being undocumented, being deprived and showing the medical card (certificate of UMA)** *** The Royal Decree of 12 December 1996 also mentions preventive care**	* Confusion about definition of 'urgent', both for people who do not know the procedure and for the health care providers, while the Royal Decree of 12 December 1996 clearly refers to curative and preventive care	* Belgian procedure for UMA acts as example for neighbouring countries (e.g. Germany) * Human rights in general and the rights of the child specifically are to be respected	* Intention to legally define the term 'urgent' (as stated in the current Belgian government agreement) potentially implies reduction of the health care package of UMA (mainly because of the political and economic context) * "Regionalising" the law on UMA possibly implies large differences in application and therefore unequal treatment of undocumented migrants * Legal vagueness creates confusion about the current beneficiaries of UMA (e.g. economically inactive European citizens are not included)



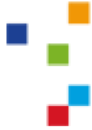
(broad definition) and guarantees confidentiality of data *** The Social Welfare Act of 8 July 1976 guarantees professional secrecy and many other aspects of the Belgian social welfare legislation are also applicable to the UMA procedure (e.g. right to get a proof of receipt)**			
A3. National policy with respect to urgent medical aid			
*** Currently there is no restricted envelope budget nor maximum ceiling for government's spending on UMA so that financial reasons cannot limit provision of care**	* Ambivalence observed in interpretation of the right to urgent medical aid (e.g. household composition, access to UMA) at the local level * There is limited public support and acceptability of the (perceived high) cost of offering UMA to UM in times of crisis * Information is insufficiently disseminated to health care providers (e.g. not all doctors/services are familiar with UMA procedures)	* Better recognition of undocumented migrants could be obtained by explicitly including UMA in health policy and plans (e.g. in Brussels Capital Region) * Role of CPAS – OCMW with respect to undocumented migrants could be reappraised in terms of more encouragement and adequate resources to implement the UMA policy * If UM would receive full coverage of care (e.g. vaccination, treatment of tuberculosis), this could have positive effects on public health * Establishment of a central control body could enable the activation of the right of UMA with one procedure, which is to be applied as standard across the country, and which gives all primary care providers the right to prescribe specialised exams * Establishment of a regionalised institution of public utility that deals with UMA only could simplify procedures for the actors involved	* Current repressive policy towards undocumented migrants * Potential fixation of the government on 'fraudulent' UMA certificates * Social insecurity of undocumented migrants due to restrictive government measures with respect to employment, health insurance, ... * Diminishing public support for UMA among the Belgian population (due to political and economic context) * Public spending cuts by the Belgian government could be used an argument to reduce the coverage of UMA * Laborious exchange of information about EU nationals and long-term residents between health insurance companies from EU member states due to the lack of a European framework

A4. Procedures granting undocumented migrants access to urgent medical aid: impacting aspects related to client characteristics			
*** The current system for UMA stays close to the people** *** The professional secrecy of social assistants at CPAS – OCMW contributes to the privacy of undocumented migrants and the confidentiality of information that is being disclosed**	* Right/procedure of UMA has to be activated when undocumented migrant changes residence to another municipality which may cause discontinuity of the right * Separate procedure of UMA for undocumented migrants - as compared to health insurance - has a stigmatising effect (especially for adolescents, e.g. during school trip)	* Declaration on honour of the undocumented migrant (cf. in France) could be considered as sufficient proof of indigence	* People with mental health problems or with distrust of CPAS – OCMW have more difficulties in consulting CPAS – OCMW * Appeal to labour court is cumbersome
A5. Procedures granting undocumented migrants access to urgent medical aid: perspective of health care providers			
*** Doctors decide independently (regardless of status of patient, no influence from other actors) about activation of the right to UMA** *** Delineation of responsibilities clarifies the role between doctors and CPAS – OCMW**	* Different practices/applications depending on doctor leads to discretionary situations * Unfamiliarity with procedures and concept of UMA (e.g. doctors on call, GP sentry) sometimes results in discussions (e.g. about the right of UMA, about terminology of 'urgent') and even delay of timely care or treatment * Right/procedure of UMA has to be reactivated when health care provider changes residence * Complexity of the MediPrima system requires technical support	* Less 'sprawl' in health care being offered to undocumented migrants if health care providers and the care provided would be controlled * Functional MediPrima is reliable, clear and understandable for everyone (i.e. hospitals, community health centres, individual doctors), but adjustments to the system needed (e.g. closing a file in case of relocation automatically allows to open the file in another CPAS – OCMW) * Increased familiarity of health care providers with the procedures of UMA results in a workable system * Activation of UMA should be possible by all health professionals	* Interpretation of 'urgent' in current terminology of urgent medical aid could imply discretionary decisions * The current procedures potentially create accessibility barriers because in theory an assessment (e.g. social enquiry) is needed first, and care is only given when the right to UMA is activated * There is a risk of reducing the duration of urgent medical aid in case of uniformisation
A6. Procedures granting undocumented migrants access to urgent medical aid: perspective of CPAS – OCMW			
*** CPAS – OCMW serve also other people seeking aid and thus no risk of ghettoisation** *** The fact that the procedure requires an enquiry of the UM's income and**	* Different interpretations and applications of the procedures among CPAS – OCMW because of territorial jurisdiction (e.g. government guidelines related to enquiry of indigence)	* Simplification of the system: (i) modification of government guidelines to enable CPAS – OCMW to elaborate a smoother and faster system for access to primary care, (ii) medical card for a longer period (e.g. 1 year) + preventive medical	* No control body for the application of UMA by the CPAS – OCMW results in different practices and possibly differences in interpretation of the regional responsibilities



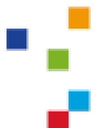
other possible financial contributors is important (but is also a weakness) **- income: makes the system more acceptable to other people who are struggling** **- residual: assessing if other potential payers could/should intervene** *** The system is geographically well spread and practically accessible for people living in small towns or villages because CPAS – OCMW present everywhere (this limits attractive power of the big cities)**	* Subjectivity in assessing indigence * Social enquiry of indigence and enquiry of territorial responsibility (not yet carried out) require (enormous) efforts from CPAS – OCMW in terms of time and human resources; this slows down the procedure and implies emotional burden for UM * Tension/gap between the image of the CPAS – OCMW as public body and the universality of access to care (which increases discrimination) * Limited duration (45 days) for CPAS – OCMW to take a decision after the care has been provided * Government guidelines do not allow CPAS – OCMW to approve UMA for more than 3 months * When CPAS – OCMW does not work properly: lack of quick decisions/extensions * No proof of receipt when applying for UMA (and often absence of written refusal) * No intervention of CPAS – OCMW for homeless people when not sure that the person lives on their territory	card (= medical card for preventive care even before care is needed) * Harmonisation of application of UMA between the CPAS – OCMW or an alternative (e.g. another political body responsible for UMA) * More transparency and greater uniformity through MediPrima * Extension of duration to notify the UM (nowadays 45 days) * Definition of what is considered 'address' and clarification of the questions that are asked during social enquiry (or not) * Understanding of government (i.c. POD MI) for CPAS – OCMW that deal with homeless people who often stay in different municipalities	* CPAS – OCMW have financial problems because the government does not intervene in the personnel costs for social enquiries * Possible fusion between municipality and CPAS – OCMW could lead to political decisions about granting UMA or not * Division of powers is not clear (e.g. between CPAS – OCMW and FEDASIL)

A7. Procedures granting undocumented migrants access to urgent medical aid: perspective of supporting NGO practices			
*** NGOs can offer the flexibility required from all teams because of changing and evolving legislation**	* Substantial efforts are required for activation and monitoring of all procedures and this is costly	* Partnerships between supporting NGOs and CPAS – OCMW could be beneficial to UM (e.g. smoother activation of the right to UMA)	* If others do not activate the right to UMA for undocumented migrants, this results in saturation of highly accessible services of supporting organisations
B. PROVISION AND QUALITY OF URGENT MEDICAL AID FOR UNDOCUMENTED MIGRANTS			
B1. Reachability of urgent medical aid for undocumented migrants			
*** Wherever possible health care will be provided to undocumented migrants through regular health system**	* Difficult access to emergency care in hospitals for undocumented migrants * Reimbursement of UMA expenses by CPAS – OCMW is limited to care with INAMI – RIZIV nomenclature code * Inequity of nomenclature of UMA for UM as compared to health care package of asylum seekers in asylum reception facilities * Waiting lists for transplantations delay treatment of undocumented migrants * Sometimes undocumented migrants are geographically limited in their choice of health care providers (far from residence of undocumented migrant) * Difficulty to have one contact person in Brussels because of unclear allocation of social workers across 19 CPAS – OCMW (per street and not thematic)	* Health care provision for undocumented migrants should be aligned to that for asylum seekers in asylum reception facilities	* Separate health care system for undocumented migrants (e.g. dispensaries) could imply reduction of quality of care
B2. Functionality of urgent medical aid for undocumented migrants			
*** Health care can be provided without having to wait for activation of UMA; control by CPAS – OCMW comes afterwards** *** Providing health care to**	* No access to prescribed treatment possible as long as UMA right has not been activated * Complexity and scope of the	* Establishment of networks of organisations that support undocumented migrants could improve efficiency * Support of health policy-makers to the social function of mediators (cf. new	* Lack of informal care (at home) or informal support base hampers full treatment (e.g. care after hospitalisation, adherence to medication, attention for social determinants of health)



undocumented migrants is not prosecutable and therefore care is sufficiently provided	administrative procedures and time limitation influence the quality of care * Variable reimbursement of the first medical consultation (if this was conducted before UMA application) due to subjective and incorrect interpretations of social assistants with respect to relevance of care	profession) could be beneficial to UM seeking health care	
B3. Availability of urgent medical aid for undocumented migrants			
*** Each patient is being helped/treated in the same way (especially by supporting organisations)**	* Difficulties in accessing care/treatment without nomenclature code * Treatments can be interrupted as a function of changes in the RIZIV nomenclature * Inadequate provision of care for unaccompanied minors (e.g. chronic diseases, personal development of the child, psychiatric disorders) * (Imposed) allocation of health professionals by CPAS – OCMW: risk of either specialisation or generalisation and risk of reduced quality of care * Limited choice in Brussels (IRIS hospitals), according to the agreements of CPAS – OCMW and due to separate accounting systems (community health centres being reimbursed on fixed rate basis)	* Few barriers to access primary health care avoid 'improper' use of emergency care by undocumented migrants * Goodwill available among professionals/organisations to collaborate to offer UMA to undocumented migrants * Financial incentives, motivation for the ("imposed") health care providers to maintain high degree of quality	* Saturation of health care providers with regards to administrative burden due to saturation of primary health care facilities * Modification of the legislation and the Royal Decree of 12 December 1996 could imply a reduction of the current provision of urgent medical aid
B4. Knowledge of urgent medical aid for undocumented migrants			
*** The public health care facilities are familiar with the system so that quality of care is being guaranteed**	* Lack of information and communication (for UM and health professionals) * Lack of information targeted at specific groups (e.g. pregnant women) * UM often do not understand the reimbursement system (e.g. D-medication has to be paid by UM themselves)	* Explanation about the health system and services accessible to UM should be given within the societal integration courses * Information about the content and procedures of UMA should be part of the curricula of health providers	* Reluctance among health care providers because existence, content and procedure of UMA is not always well known * Improper use of emergency services by undocumented migrants because both the Belgian health system as the UMA procedure are not sufficiently known

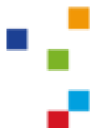
B5. Affordability of urgent medical aid for undocumented migrants			
*** Broad care package being offered to UM: care with nomenclature code shall be borne by the federal government, no co-payment will be requested from UM, other medical care may also be paid by the CPAS – OCMW in function of the emergency and the situation**	* Only medical care can be reimbursed while availability of accommodation and food has implications on the treatment (e.g. malnutrition, street life) but is not always affordable to UM * Supporting organisations have to pay in advance until the UMA procedure is activated (and no retroactivity of the right to UMA)	* More treatments with nomenclature code imply higher accessibility (e.g. consultation of a specialist in psychology)	* GPs are not always familiar with the UMA system and therefore refuse patients with medical card * Government spending cuts could have impact on coverage of urgent medical aid
B6. Reliability of urgent medical aid for undocumented migrants			
*** Public health care services are familiar with the system so that quality of care is being guaranteed (like for persons with health insurance)**	* A priori limitation of the role/radius of action of organisations supporting UM (not in favour of social determinants of health)	* Implementation of a flexible and effective health policy could increase access to care * Establishment of a broader network of supporting organisations could lead to better coordination and more efficiency of support given to undocumented migrants	* Medical professional secrecy while medical certificates need to mention the medical diagnosis and are addressed to non-medical users * Protection of privacy of undocumented migrants is not always guaranteed
B7. Comprehensibility of urgent medical aid for undocumented migrants			
*** Most undocumented migrants know that they are entitled to health care** *** Good practices to inform undocumented migrants about UMA (e.g. websites, leaflets, specific units for UMA) enhance health literacy**	* Limited access to free interpreters (sometimes available in hospital, rarely outside hospital; expensive for individual practitioners, supporting organisations are not compensated) * Language barrier: public welfare workers, e.g. KindGezin (depending on Flemish government), have to use Dutch, but CPAS – OCMW social workers who do not speak Dutch are not able to translate letters for UM	* If full access to interpreters, better diagnosis and care could be provided and unnecessary health care costs could be avoided * Availability of easily accessible/downloadable leaflets with the most common health complaints in most common languages would increase comprehensibility of UMA for undocumented migrants	* Reluctance of doctors to treat undocumented migrants because of language barriers hampers provision of care



APPENDIX 8. SWOT ANALYSIS BASED ON INPUTS FROM UNDOCUMENTED MIGRANTS

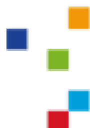
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
A. LEGAL AND POLITICAL FRAMEWORK AND PROCEDURES			
A4. Procedures granting undocumented migrants access to urgent medical aid: impacting aspects related to client characteristics			
*** Procedures have been simplified for UM with introduction of the medical card** *** Current procedures allow to activate the right to UMA before being ill**	* Undocumented migrants need to 1) give an address to CPAS – OCMW; 2) prove health needs to CPAS – OCMW; 3) to accept a social inquiry, including the visit of the CPAS – OCMW's social assistant at the given address * Complexity and burden of the UMA procedures at level of CPAS – OCMW due to: 1) asking migrants to come back over and over again for a potential future step (straining the procedure); 2) changing formalities; 3) need to come several times for a single procedure * Additional requirements when seeking medical aid increase complexity and burden of the procedures: 1) need to go first to CPAS – OCMW before accessing health services; 2) gatekeeping system when accessing specialty care (i.e. having to consult a GP first); 3) need to meet health professional first before initiating a treatment	* Support from NGOs helps to obtain UMA, while some organisations provide specific care/treatments too	* Access to the health care system besides UMA is problematic for undocumented migrants : 1) they can either not seek help or wait until the problem becomes severe; 2) they rely on informal care/network/friends/family; 3) they rely on self-medication/self-medicine
A6. Procedures granting undocumented migrants access to urgent medical aid: perspective of CPAS – OCMW			
*** For some of the CPAS – OCMW, formalities have changed and become easier for UM (e.g. no need to go first to the CPAS – OCMW before accessing health services)**	* Refusals by the CPAS – OCMW due to administrative reasons (stated as 'not complying with conditions to receive UMA') or because health care was deemed not necessary	* CPAS – OCMW do not check address anymore which is seen as opportunity for easier provision of the medical card and better provision of care as well	-

	* Refusals to grant UMA are often given to UM without any explanations		
B. PROVISION AND QUALITY OF URGENT MEDICAL AID FOR UNDOCUMENTED MIGRANTS			
B1. Reachability of urgent medical aid for undocumented migrants			
*** When living inside a city centre, health services are well reachable and close to the address of the undocumented migrant** *** Referral system works well:** **a) UMA procedure can be initiated by the health professional/health service;** **b) public social and health services generally refer UM to the adequate service; and** **c) access to services is helped by appropriate referral between social and health services**	* When living outside city centres, reachability is limited because a) health services are not close to UM's address; b) refusals from health services/professionals in the close neighbourhood; implying extra costs for public transport or long walking distances to health services * Temporal aspects because of 1) length of the procedures; 2) long waiting time in health and social services; 3) limited opening hours or specific time slots at CPAS – OCMW; 4) need to come several times for a single procedure in social services * Referral from (private) to (public) health service or from public social service to NGO because not complying (yet) with the conditions	* UM indicate NGOs and informal network, friends and family as the most important agents of support when accessing social and health services (mainly in terms of emotional and financial support, or offering help to negotiate or to translate)	* UM being referred from one service to another without being cared for (for social and/or health issues) has implications for health status of undocumented migrants, and in some cases for public health too (e.g. no vaccinations, no proper treatment of TB)
B2. Functionality of urgent medical aid for undocumented migrants			
*** Simplified procedures in CPAS – OCMW in specific situations (e.g. no need to apply for the prolongation of urgent medical aid when suffering from a chronic disease, or when being pregnant)** *** The health care package is adapted to the specific situation of the UM (e.g. pregnancy, chronic diseases)**	* Continuity of care (between two procedures or between two episodes of disease) is hampered by 2 factors: 1) the need to renew the application for UMA every x months (resulting in e.g. refusal of care when UM is waiting for a prolongation of UMA or no health care being provided when the UM is waiting for the procedure), 2) lack of coordination between primary care and hospital	* NGOs adapt themselves to the needs of undocumented migrants by providing health care services not covered by the UMA or by providing free treatment or medication to UM * Possibility of an automatic extension of the validity of the medical card (more than 3 months) could be a solution for continuity of care as the UM do not need	* Non-inclusion of social determinants of health (e.g. housing, food, transportation) could jeopardise the effectiveness of the provided medical treatment



*** Some CPAS – OCMW give autonomy to undocumented migrants to freely choose health care professionals/services (e.g. primary care or pharmacies)**	services / between CPAS – OCMW & pharmacists / between health professionals in the same hospital * Limited autonomy for undocumented migrants who are not allowed to freely choose their health care professional/service	to come back too many times to renew his/her application (particularly in case of pregnancy or chronic disease)	
B3. Availability of urgent medical aid for undocumented migrants			
*** CPAS – OCMW allow the UM to freely choose the health care provider**	Availability of health care is limited because 1) health services/professionals are chosen by the CPAS – OCMW; 2) CPAS – OCMW provides a list to choose from; 3) CPAS – OCMW address preferentially patients to integrated health services (e.g. community health centres such as 'Maisons Médicales' or 'Wijkgezondheidscentra'); 4) denial/referral by the health care services themselves	* If undocumented migrants could freely choose health services/professionals everywhere, they would experience more/better availability	
B4. Knowledge of urgent medical aid for undocumented migrants			
*** Good reputation of the health care providers (e.g. being excellent in specific medical areas, being helpful towards undocumented migrants) influences help-seeking by undocumented migrants**	* Information (e.g. about the Belgian health system in general, about the content and procedures of urgent medical aid specifically) is lacking or not readily available to undocumented migrants	* Being in the system before being undocumented (e.g. asylum seeker) helps to get information about the Belgian health system * NGOs act as intermediary between UM and mainstream (health) services, and are seen as enablers to get access to UMA but presence of an informal network is perceived by UM as the best enabling factor to provide information about mainstream health services, NGOs, and rules/procedures to get urgent medical aid	

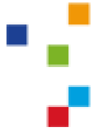
B5. Affordability of urgent medical aid for undocumented migrants			
*** (Financial, administrative, psychological) support from (non-governmental) organisations facilitates access of undocumented migrants to health services and social services**	* Barriers to affordability identified at the health service level are: 1) some acts/treatments are not covered by the CPAS – OCMW (e.g. medication); 2) some pharmacies refuse delivering medication if the UM do not pay beforehand or refuse being charged by the CPAS – OCMW; 3) health professionals refuse providing care because of the uncertainty or delays in reimbursement; 4) UM have to pay beforehand * For the undocumented migrants themselves, barriers related to affordability are: 1) not being able to afford health care fees; 2) additional fees or co-payments are not reimbursed (e.g. patients are seen by specialists outside convention with INAMI – RIZIV)	* Financial access to urgent medical aid is facilitated by family/friends/relatives paying for the UM * (Financial) support from NGOs, civil society organisations or from the community makes health care more affordable and accessible * Allowing undocumented migrants to work may help them to get money for healthcare and can be a relevant opportunity to develop themselves	* If psychological assistance/therapy is not offered, UM cannot be treated for mental health aspects as e.g. trauma and stress related to their status
B6. Reliability of urgent medical aid for undocumented migrants			
*** UM appreciate that health care providers first provide care and treatment, and only afterwards take care of administrative aspects** *** Following attitudes have been cited as positive in the relationship with and reliability of health professionals: 1) empathy, kindness, attention and respect;** **2) ethnic concordance/matching;** **3) equal treatment regardless of UM status;** **4) no stigmatisation, stereotyping or labelling**	* UM report negative attitude towards - social assistants at CPAS – OCMW due to a) lack of empathy, kindness, attention, respect; b) holding back or providing incorrect information; c) administrative errors; - health professionals because of a) absence of systemic approach to UM & family; b) lack of privacy; c) many administrative errors and some medical errors;		* Undocumented migrants perceive themselves in a weak position to obtain UMA from CPAS – OCMW because 1) they have been threatened by CPAS – OCMW to be reported to the police; 2) they fear being deprived from the limited social support if providing address to CPAS – OCMW; 3) they are afraid of implications for the persons hosting them when providing address to CPAS – OCMW * Barriers to reliability at patient level are due to:



*** Satisfaction with the care received and expressions of gratitude to the Belgian government and to the CPAS – OCMW**	d) reluctance to care for UM; - both social assistants and (to lesser extent) health professionals because a) stigmatisation, patronising, belittling, excessive familiarity; and b) different attitude/treatment when UM is accompanied by professional/volunteer from supporting organisations * Decision-making process of activating UMA is flawed by a) variation of quality of services provided depending on the professional or the day; b) discretionary decisions by health professionals or by CPAS – OCMW; c) unclear definition of "urgent"; and d) lack of a definition of the health care package/nomenclature covered by UMA		1) mistrust of social assistants or health care professionals vis-à-vis undocumented migrants; 2) anxiety; 3) feeling that everything was scrutinised by the CPAS – OCMW, that everything should be justified, or that controls were excessive; 4) racism; and 5) afraid of asking information
	* Collaboration between social and health services is perceived difficult because of 1) contradictions between recommendations of health professionals and decisions of CPAS – OCMW; 2) contradictions between procedures applied by CPAS – OCMW and practices of health professionals		
B7. Comprehensibility of urgent medical aid for undocumented migrants			
*** UM appreciate that health care providers/facilities make efforts to communicate in common language**	* Undocumented migrants experience communication problems due to language barriers, both at CPAS – OCMW or in health facilities * UM often do not get justification for negative decisions taken by CPAS – OCMW * Limited health literacy or knowledge of the Belgian health system makes it difficult for undocumented migrants to understand the complex UMA procedures	* Better/more supply of (professional) interpreters, both at CPAS – OCMW or in health facilities, would help undocumented migrants to better understand the health system or the treatment proposed * Information sessions for UM - especially for UM with low health literacy and/or low socioeconomic status- and training and education for the health care professionals would contribute to more comprehensibility of UMA	

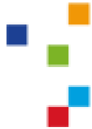
APPENDIX 9. SWOT ANALYSIS BASED ON INPUTS FROM HEALTH CARE PROFESSIONALS

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
A. LEGAL AND POLITICAL FRAMEWORK AND PROCEDURES			
A2. National legislation with respect to urgent medical aid			
* **UMA is a fundamental right and entitles undocumented migrants to receive preventive and curative care**	* The law (Royal Decree) on UMA stems from 1996 and is not in line with the current migration scope * Current legislation leaves room for interpretation which creates discretionary situations. Especially the wording of 'Urgent Medical Aid' is problematic as it induces misunder-standings for 2 of the 3 words: 1) "urgent" and 2) "medical" as the (legal) scope of UMA is much broader than what is generally understood by these terms. As a consequence, several UM are refused care, because health professionals and social assistants interpret "urgent" as in "emergency" and "medical" as in "strictly medical" * UMA legislation changes regularly and is "regionalised" at implementation level, thereby adding an additional level of variation to the Belgian model, and often accompanied by additional paper work, both at the level of the health facility and the CPAS – OCMW	* Clear definition of urgent medical aid would result in less ambiguity and arbitrariness: a) replace the word "urgent" by "necessary" or "essential" as this reflects better the type of care needed; b) replace "medical" by "health" * In case of administrative simplification of the procedures, current bureaucracy could be reduced	* In case of harmonisation of UMA procedures, there is a potential reduction of UMA coverage in those cities where currently a broader scope is applied
A3. National policy with respect to urgent medical aid			
	* MediPrima system currently limits reachability of services to the ones available in the region having an agreement with CPAS – OCMW	* If procedures would be standardised and simplified for all (regardless of the status one has), with an electronic social patient file and well-functioning	* Harmonisation could also reduce the quantity and quality of care that is now guaranteed in some towns/municipalities

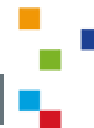


		MediPrima system (to be consulted at any time and processing data in a timely manner), this would not leave room for interpretation	* With the MediPrima system CPAS – OCMW are in charge of indicating the type of care needed, while this should be the responsibility of health care providers
A4. Procedures granting undocumented migrants access to urgent medical aid: impacting aspects related to client characteristics			
* **When UM are not being able to give address, health services declare that patient is homeless in order not to endanger this precarious situation but to assure that medical card is provided**	* The fact of having first to prove address and financial situation, and to accept social enquiry from CPAS – OCMW before receiving medical card strains the health care provision; these administrative requirements are considered as criteria of exclusion rather than inclusion * Some undocumented migrants cannot disclose real address as this might endanger their precarious stay and support from other people in precarious situations or out of fear for (police) repercussions * In addition to the medical card, UM also need to prove every consultation with a certificate and bill	* The UMA procedure could be simplified by not requiring from the UM to provide an address	* Provision of care to undocumented migrants is being hampered due to complexity - seems as if current UMA procedure is meant to be a direct barrier in order to strain access deliberately * Declaring uncertainties (e.g. about co-housing, homelessness of UM) by the health care service can be interpreted as false statements in order to get paper work done and health care reimbursed
A5. Procedures granting undocumented migrants access to urgent medical aid: perspective of health care providers			
* **Health care providers and social services of health facilities initiate UMA procedures themselves, often arranging language assistance and administrative work before the UM attends the health facility** * **Pro-active interventions and preventive referrals (e.g. in case of newborn children, children, pregnant women) by health care providers**	* The UMA procedures imply extra burden for health care providers/facilities that initiate UMA * Health care professionals initiating UMA procedures are transgressing their medical responsibilities (i.e. not their task) and jeopardising their medical secrecy (i.e. by disclosing medical information about the patient; some health care providers already feel that they have	* If all actors involved stick to their responsibilities as defined by law, there would be no swapping of roles: health care professionals define the medical care needed, while CPAS – OCMW check financial needs and status to arrange reimbursement administratively * Social services of (large) health facilities could be pro-active by contacting UM in order to arrange papers and language assistance before they come to the doctor	* Professional (medical) secrecy might be at risk if health care providers need to contact and inform social assistants of CPAS – OCMW * Sovereignty of doctors to define what is medically urgent or essential is at risk (e.g. being overruled by CPAS – OCMW doctor)

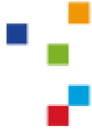
*** Good practices in health facilities for monitoring the UMA procedures at CPAS – OCMW level, e.g. introduction of an (electronic or manual) "expiration diary" by their social assistants to notify them if the papers are being processed and getting arranged or not (because proof of receipt of UMA application is rarely given by CPAS – OCMW) so that they can contact the relevant CPAS – OCMW services in due time** *** When performing well, MediPrima simplifies the current procedures for health facilities**	entered the twilight zone and are disclosing a lot of medical info) * For a solo GP the UMA procedure is nearly infeasible to comprehend and arrange without administrative support; for community health centres and hospitals it requires enormous efforts from their social assistants * There is lack of coordination between (1) primary/secondary/tertiary health care services and supporting social services and (2) peripheral and city centre services	* Simplification should be considered in order to protect (the medical role of) the doctors: 1) at hospital level: introduction of a consultation voucher which provides health care professionals the opportunity to provide the necessary care without having to think about remuneration or administration and gives the patients the certainty that they will be seen by a doctor but that empower them to take up responsibility and to arrange the paper work with support of social service, 2) at community health centres: same care for everybody so treatment is assured, but paradoxically the paper work stays	
A6. Procedures granting undocumented migrants access to urgent medical aid: perspective of CPAS – OCMW			
*** Goodwill is present in CPAS – OCMW staff to accept specific justifications (e.g. 'sleeps on a public bench' as address) or to personally visit the patient when being hospitalised so that procedures can be activated**	* Refusals by CPAS – OCMW to grant urgent medical aid occur because undocumented migrants do not have domicile address * Social enquiry by CPAS – OCMW slows down or blocks the activation of the UMA right * CPAS – OCMW refuse treatments that are considered necessary by health care providers and overrule their decision * CPAS – OCMW decide to reimburse less treatment than standard protocol because of cost * CPAS – OCMW only deliver medical	* Compliance of the CPAS – OCMW with UMA legislation guarantees activation of the UMA right to those entitled to get it * Respect of role and responsibility of each party involved would create less ambiguity in decisions on urgent medical aid * There should always be a possibility of submitting a rebuttal and not letting incorrect refusal by CPAS – OCMW pass by	* UM are not getting the medical care they are entitled to, due to CPAS – OCMW not sticking to their role and not implementing the law correctly * Even with functional MediPrima system, CPAS – OCMW remain the intermediary level between UM and health facilities and thus discretionary decisions remain possible * In some cities CPAS – OCMW state that they can only work with a few hospitals they have agreements with, thereby limiting the accessibility and choice of health care provider while UM should have equal patient rights as other patients



	cards for one or a few days while this is against the law * UM from European countries are refused UMA but are not referred elsewhere * Refusals to grant urgent medical aid happen because of heavy workload * CPAS – OCMW prefer having agreements with hospitals while the type of care should often be dealt with at primary health care level		
B. PROVISION AND QUALITY OF URGENT MEDICAL AID FOR UNDOCUMENTED MIGRANTS			
B1. Reachability of urgent medical aid for undocumented migrants			
*** Referral in between services of the same health facility facilitates access to urgent medical aid**	* Referral depends on who refers you to a health service and/or social service, creating faster access to some and slower to others * Procedures are too long, both for the UM in need of care as for the health facilities that are involved before being able to start up treatment, thereby hampering correct treatment and adherence of UM * Opening hours of CPAS – OCMW strain the procedure	* Make arrangements for UMA by phone or online is time-saving for all parties involved and reduce negative temporal aspects related to UMA procedure	* Length of UMA procedures hampers correct treatment and adherence of UM, thereby jeopardising the UM's health status, even endangering their life (depending on the health condition)
B2. Functionality of urgent medical aid for undocumented migrants			
*** Medical care is being offered by health facilities without knowing whether it will be refunded** *** UMA coverage is extended in specific**	* UMA coverage is not the same across Belgium which leads to unequal treatment * Dependence of undocumented migrants on own means and/or support from	* UMA procedures should make provision for standard extended coverage for vulnerable groups in specific situations (e.g. pregnant women, newborn children, children) * Continuity of care should be guaranteed	* Vulnerable groups such as pregnant women and newborn children get into worse or even life-threatening health situations if not provided with appropriate care * Straining UMA procedure and unequal

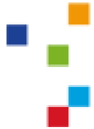


situations: e.g. pregnant women, newborn children, children *** Continuity of care is assured through:** **1) internal referral in between services,** **2) providing medication from proper pharmacy stock to assure effective treatment**	charity and NGOs hampers proper treatment * Continuity of care is at stake due to the slow process and often delay in getting the medical card; this can hamper the effective treatment * Continuity of care is not assured in between procedures and services because decision on referrals or coverage depends on CPAS – OCMW so that UM have to rely on support from charity/NGOs/friends during periods of non-activation of UMA * Continuity of care is not guaranteed when UM is discharged from hospital because 'after care' cannot be offered (not reimbursed or too expensive because of private services)	for whole household through simplified and standard procedure with electronic administration system * Introduction of a consultation voucher should be considered (e.g. every patient who arrives at emergency department or policlinic who is not known or does not have financial means is given a consultation voucher at check-in and is seen by a doctor who then must indicate the type of care needed: 1) emergency care → no reason to impede, avoid or delay care; 2) care is necessary but can wait a maximum of 10 days → patient is then seen by hospital's social assistant who will help with paper work to obtain medical card; 3) one consultation is given, but patient could have been treated at first line → this is explained to patient who is brought into contact with GPs in the neighbourhood and urged to arrange paper work)	treatment induce drop-out and non-adherence of patients, which endangers their health (and even public health) * Unequal treatment of services who undertake steps to start medical care/treatment and those who don't
B3. Availability of urgent medical aid for undocumented migrants			
*** Referring undocumented migrants to a limited number of services (cf. lists of doctors and pharmacies)** **(1) reduces the time they need to invest to find proper care and** **(2) guarantees them a health care provider who is also administratively able to take care of them and who knows the procedure**	* Availability of the health services either limited by the CPAS – OCMW or by health facilities: - CPAS – OCMW choose to which type of facility they refer, make agreements with, or accept to work with (this constraint often leads to undocumented migrants calling on or being referred to secondary health services while medically spoken primary health facilities are more apt to take up this care) - health care providers do not want the hassle to go through all the UMA paper work and to work with CPAS – OCMW or do not want to have undocumented migrants as patients (e.g. private	* Simplification and standardisation of UMA procedures so that it becomes easier for any health care provider to provide the necessary care * If simplified administration is not feasible, establishment of a multidisciplinary "focal point" or "referral centre for UM" could be considered, combining administrative (CPAS – OCMW tasks now), judicial, psychosocial and medical aspects at one spot	* The consequence of establishing a focal point or referral centre (see opportunities) might imply a too heavy burden on public hospitals

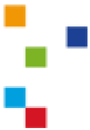


	hospitals refusing undocumented migrants)		
B4. Knowledgeof urgent medical aid for undocumented migrants			
*** Undocumented migrants are being informed, supported and/or referred by social services and non-governmental organisations to access UMA**	* Lack of available and/or correct information at different levels: a) for the undocumented migrants about the Belgian health system in general and the UMA procedure specifically; b) for the health professionals about the UMA definition, especially the term "urgent", and the reimbursement of treatments and medications by the CPAS – OCMW in charge of the UM patient * Misperception of the general public, health professionals and policy makers on the number of undocumented migrants who are seeking health care in Belgium for free and should be considered medical tourists	* Patient rights are also applicable to undocumented migrants and it is the responsibility of the health facilities to guarantee, as an indicator of quality, that the patient is well-informed and if needed, assisted in his/her proper language to enhance knowledge * Training of health professionals and availability of innovative information tools (not only leaflets) on current UMA definition and procedures (but this may not be needed if the UMA system would become more transparent and standardised, so that the health professionals do not need to specialise in UMA procedure)	* Medical tourism to cities where CPAS – OCMW and health care facilities are known to cover more services could imply extra (administrative and financial) burden for those CPAS – OCMW and health facilities
B5. Affordability of urgent medical aid for undocumented migrants			
*** Community health centres are highly accessible because they are affordable for undocumented migrants** *** Health facilities rely on proper stock of medication to ensure the right medication is given and adherence to treatment is facilitated** *** When saturated or when specialised care cannot be offered, primary health facilities and target-group specific health services such as ONE/Kind & Gezin refer to health care providers who have agreed to work at 'reduced fee' (e.g. gynaecologists, GP sentries, laboratories)**	* Health professionals/facilities refuse to provide care or medication for financial reasons: a) UM cannot pay an instalment upfront or cannot bear the full costs or extras in case of a non-conventionalised specialist; b) delays in reimbursement by CPAS – OCMW up to 6 or more months; c) uncertainty whether CPAS – OCMW will accept the full treatment and reimburse correctly; d) not all treatments/acts are covered by the list used by CPAS – OCMW	* Possible facilitators to make UMA affordable for undocumented migrants at health service level: a) payment by capitation would make the system more equal, just and feasible in a timely manner; b) the first consultation could be for free or embedded in a consultation voucher; c) giving the right to health insurance coverage through mutuality from the moment a person resides on Belgian territory for indefinite time; d) universal coverage at least at European level to start with	* Risk that an "all-patient-diagnosis-related groups" funding system (as is the case for hospitalisations) is being installed for urgent medical aid for undocumented migrants which could induce 'health care at several speeds' * Potential tension between goodwill of staff to provide support and care on the one hand and increasing cost of UMA for health facilities on the other hand (because not all services are being reimbursed or only with significant delay so that Board of Directors puts pressure on staff)

B6. Reliability of urgent medical aid for undocumented migrants			
*** Social assistants (at CPAS – OCMW or at health facilities) and health professionals do not differentiate between undocumented and documented migrants/citizens and provide the same package and quality of care to all regardless of the status or any other characteristic one can have** *** Patients and health professionals are given cards with the explanation of what UMA entails to avoid discussion on what is covered and what not** *** Health professionals/services and social assistants/services who have taken decisions that are not in line with the law (e.g. refusing to sign card while care is urgent/necessary) are being directly addressed by the head of the social service of the health facility and if proven to be a systematic issue it is taken to the board of the health facility** *** Examples of social services providing the patient with a coloured paper (e.g. in pink so that they clearly remember what it is for) which the CPAS – OCMW needs to sign for receipt indicating a date and to be brought back to the health facility for closely monitoring the procedure**	* The decision-making process on provision of UMA or not is flawed by a) health professionals not wanting to sign the statement that the care is medically considered as UMA even though according to the law it should be considered as such; b) CPAS – OCMW scrutinising every decision or step taken by every actor exceeding the necessary level of control; c) CPAS – OCMW overruling the decision of the health professional stating that it cannot be considered UMA; d) discretionary decisions among CPAS – OCMW or among staff of same CPAS – OCMW on what is considered UMA or on extra coverage for some treatments/interventions/medications * Lack of required skills of social assistants and/or health professionals: a) communication skills; b) not being able to manage correctly the power they have on vulnerable people (e.g. breach of privacy, refusal of speaking other language than mother tongue, abuse of the vulnerable position of the UM, illiteracy of the system); c) not being able to put their personal political or moral values aside	* It is essential to discuss openly and if necessary report any breaching of the UMA legislation both at the level of what UMA entails (preventive and curative care) as at the level of roles and decision-making power (every stakeholder should stick to his/her proper role) * Name change and more standardised and transparent procedures could help to reduce the possibility to take discretionary decisions * Clear definition at federal level of who is entitled to care and what care is covered under UMA so that discretionary decisions at local level can be avoided * Quality in providing UMA should be assured: a) any health professional and social worker should be well trained in communication in general and in intercultural communication specifically; b) staff working in this sector should be well screened on the required professional skills before they are hired; c) staff should be regularly evaluated on their quality of care provided	* Current level of discretionary decisions taken at the CPAS – OCMW as well as at the health facilities breaches the right of undocumented migrants to health and health care * Undocumented migrants risk not to be treated with dignity and respect, to be discriminated against or to be maltreated because of their status because of lack of professionalism
B7. Comprehensibility of urgent medical aid for undocumented migrants			
*** Substantial efforts made by staff from social/health services or supporting organisations to sensitise,**	* Limited health literacy at all levels: a) the undocumented migrants; b) the health	* Provision of interpreters, other interpretation tools (e.g. tablets) and intercultural mediators from the moment undocumented migrant arrives in the	* Individual GPs cannot afford to understand all UMA procedures and rules



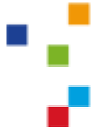
inform, empower the undocumented migrants to get access to UMA *** Increased offer of interpreters and/or intercultural mediators in (large) health facilities for improved information-sharing and communication** *** Information on UMA or face-to-face translation possibilities made available in several languages in (large) health facilities (e.g. list with all languages spoken by hospital staff)**	professionals; c) the social assistants of CPAS – OCMW or health facilities * Difficulties in being correctly informed and continuously updated on new aspects of UMA procedures (e.g. social workers at CPAS – OCMW but also in health facilities)	health facility could improve health literacy of the UM * Training of health care professionals in certain pathologies that are more frequent in other parts of the world, in intercultural communication, and in migrant and global health in general should be included in study curricula to improve their information and communication skills	(and to arrange the administrative burden)



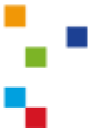
APPENDIX 10. RESULTS OF THE LITERATURE REVIEW

Table 12 – Review of studies according to the 7B framework and the target groups of the interventions (n=14)

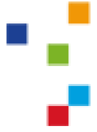
Author	Reachability	Functionality	Availability	Knowledge	Affordability	Reliability	Comprehensi-bility
Arredondo et al.	Developing binational policies	Strengthening the infrastructure of health services	Broadening the range of providers and suppliers of public health services	Involving the NGO within the process of identifying priorities and developing plans	Ensuring financial protection from catastrophic health expenditures	Involving of political stakeholders, governmental stakeholders at local level	Developing programs in high priority communities
Wallace et al.	Expanding community access "safety net"		Using telemedicine for specialty care		Providing employer mandated health insurance; Supporting binational health insurances		Providing culturally competent care and bilingual staff within safety net system; Providing care rather than coverage, including additional resources for primary care and prevention
Torres Cantero et al.	Developing health policy (medical cards and free medical care in equal terms than the legal migrants)						
Strassmayr et al.	Developing policies and legislation supporting access to mental health care Adapting administrative arrangements to accommodate the frequent inability of			Providing relevant information to health care professionals and administrative staff by care providers and professional associations Providing information about			Providing of culturally sensitive care, including the provision of interpreting services and/or multilingual staff



	UM to prove identity or residency			entitlement to health care for UM Providing of relevant legal advice and social counselling		
Stevens et al.	Expanding outreach and enrolments to existing programs			Developing community-based organisations	Having a separate insurance program to cover otherwise ineligible children	
Frates et al.	Developing "open door" services (no condition to access the services)	Ensuring continued outreach and case management to maintain contact		Having an educational outreach campaign to encourage use of benefits; developing proactive member education and orientation processes Organising quarterly grantee meetings of stakeholders to coalesce and move forward	Developing "open door" services Funding of services through a mix of internal and external / private and public funding to sustain the programs over time	Relying on gatekeepers, such as community organisations that support UM children, for example through migrant education, schools and community providers
Gonzales et al.					Providing temporary social security numbers	Developing deferred action for childhood arrivals (DACA): relief from deportation, renewable work permits, and temporary social security numbers
González Block et al.					Developing bi-national health insurance	



Gray & Van Ginneken		Focusing on segments of the population, specific protection for children / pregnant women			Allowing migrants to purchase insurance Ensuring universal coverage act (publicly financed insurance coverage) Having a separated tax-funded system, national health service		Delivering specific types of services
Liebert & Ameringer	Developing safety net				Delivering free health care provided within the safety net Providing services outside the mainstream government funding		Having community health centres Having emergency rooms Having free clinics
Martinez et al.	Granting minimum rights to health services through laws and policies, Granting more than minimum rights to health services through laws and policies	Increased access to comprehensive primary care, prenatal care, and chronic disease management may make better use of the public health funding by alleviating the need for costly emergency care	Having emergency rooms				Strengthening health care service provision by building new strategies: volunteer interpreter services and culturally and linguistically appropriate programs.
Nandi, Loue & Galea		Encouraging UM to obtain clinically effective vaccinations and screening for prevalent infectious diseases through national immigration policy	Developing free clinics				

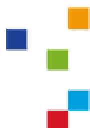


Ruiz & Briones-Chavez	Developing mobile clinics	Building of referral systems by HCP	Developing culturally sensitive interventions
de Graauw	Providing municipal ID cards	Providing better information to UM in the community organisations about life in the United States, their legal rights, becoming a citizens, and educational opportunities.	

APPENDIX 11. INFORMATION SHEETS PER COUNTRY

Table 13 – Access to healthcare for undocumented migrants in The Netherlands

Administrative procedure	Linkage Act: UM have no right on any support, except medically necessary care and care needed in situations that would jeopardize public health Commission Klazinga (2007): definition of medically necessary care= well-considered and appropriate medical care which is equal to care for insured inhabitants (verantwoorde en passende medische zorg) Reform 2009: Zorginstituut Nederland (ZN) responsible for the reimbursement % of the healthcare providers who risk to lose income due to the care provision to UM. This reimbursement is only available if the UM is not able to pay the bill (which should be examined by the healthcare provider) and is limited to a list of healthcare facilities and providers under contract to Zorginstituut Nederland (ZN) (previous College voor Zorgverzekeringen) Reform 2014: 5euro out-of-pocket payment in pharmacists
Conditions	Reimbursement only available if UM is not able to pay the bill (collection offices and/or payment contract) Access to care similar to basic insurance coverage of insured inhabitants Exception for the 5euro measure: patients with chronic medication use who receive a weekly medication package ("vervolg weekuitgifte").
duration	Pharmacists: medication up to three months (similar to insured inhabitants)
Health services	HIV screening: free of charge and anonymous only in local public health services (GGD) or sexual transmitted diseases clinics HIV and other infectious diseases treatment: is always considered as medically necessary Primary care: direct access to GP Ante and postnatal care: direct access Specialists: dentists no refusal of basic care (care provided in basic coverage) (paramedical) secondary care: similar access as insured inhabitants Hospitalisation: direct access can be restricted by lack of ID, referral needed by GP, emergency care should always be provided Additional care services: mobility aids only on referral by GP and in organizations on contract with ZN, direct access to transport by ambulance, other transport only in organisation on contract with ZN
alternatives	/
Financing	Primary care: 80% reimbursement by ZN, 100% reimbursement in pregnancy or delivery Ante and postnatal care: 100% reimbursement by ZN Specialists: dentists 80% reimbursement by ZN (paramedical) secondary care: 80% reimbursement by ZN Hospitalization: out-of-pocket for the UM or reimbursement for the hospitals by ZN (reimbursement for all hospitals for emergency care, for non-emergency care only reimbursement for list of hospitals recognized by ZN)

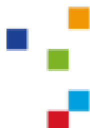


	Medication: only in pharmacists who have a contract with ZN + 5euro out-of-pocket payment Additional care services: mobility aids 80-100% reimbursement by ZN, transport by ambulance 80-100% reimbursed by ZN, other transport only organisations on contract receive reimbursement of 80-100% by ZN
Children	No access free of charge unless care is medically necessary. Vaccinations not compulsory and free of charge.
Risk for expulsion	Article 64 application: expulsion suspended as long as state of health would make it inadvisable to travel. The termination of the medical treatment would lead to a medical emergency (duration less than 1 year). Same insurance than asylum seekers. Permit for medical emergency: access to health care as authorized residents
Potential facilitators and barriers	Different interpretations by healthcare providers If they cannot pay, risk for incasso offices Unawareness by migrants and health care providers New funding scheme (reform of 2009): only 80% reimbursement of primary care, increased distance to contracted centres, dental care >21y no reimbursed, psychotherapeutical care less accessible. Healthcare providers/institutions have to provide evidence of their efforts to claim the indebted amount from the patient. Full reimbursement for obstetrical and pregnancy-related care. In 2014, 132 communities had no licensed pharmacy, which could hamper the access. In 20% of the UM, the 5euro is paid by a third party (church, organisations, community). The number of recognised hospitals has increased from 16 (in 2013) to 31 in 2014.
references	ilegaalkind.nl https://www.zorginstituutnederland.nl/binaries/content/documents/zinl-www/documenten/rubrieken/organisatie/1404-vijf-regelingen-voor-bijzondere-groepen/1404-vijf-regelingen-voor-bijzondere-groepen/Vijf+regelingen+voor+bijzondere+groepen.pdf 8ste monitor regeling financiering zorg onverzekerbare vreemdelingen Antwoord Minister Schippers nr Tweede Kamer betreft verzekerdenmonitor 2014 van het Ministerie van Volksgezondheid, Welzijn en Sport

Table 14 – Access to healthcare for undocumented migrants in France

Administrative procedure	Parallel administrative system: Aide medical état (state medical assistance)(AME) Normal procedure (longer in time) Priority procedure (on grounds of urgency) Application should be sent to health insurance (caisse primaire d'assurance maladie (CPAM)), decision should be taken within 2 months. If approved, AME-card should be picked up and should be shown to the healthcare provider Attempt to reduce AME coverage from 100% to 75% (not yet regulated)
Conditions	Proof of identity of applicant and dependants Uninterrupted residence for more than 3 months (+evidence of an address) Under a certain economic threshold for the last 12 months (depending on the place of residence and the composition of the household) ➔ Picture compulsory for UM and all persons older than 16y, declaration on honour in addition to proofs of identity, residence and resources

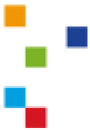
	➔ AME card is delivered by sickness fund (caisse primaire d'assurance maladie) ➔ In case of emergency care/hospitalisation: AME can be requested within 30days after admission in hospital
duration	1y
Health services	All types of health services except optical products, hearing aids and some dental prosthesis, all care services related to fertility problems Primary care: same access as nationals Ante and postnatal care: same access as nationals Specialists: same access as nationals (paramedical) secondary care: same access as nationals Hospitalisation: same access as nationals Additional care services: UM living for at least 3 years in France, eligible for home medical assistance, allowing them to receive primary care free of charge
alternatives	If not eligible for AME, only entitled to Permanences d'accès aux soins de santé (PASS): emergency care, treatment of contagious diseases, all types of health for children, maternity care and abortion for medical reasons; screening of sexually transmitted diseases and HIV/AIDS, family planning, vaccinations; screening and treatment of tuberculosis in specialized centres→ reimbursement via fund "fonds de soins d'urgence" on case by case basis If residence for more than 3 years: eligible for home medical assistance (primary care free of charge) If sufferers of work accidents and occupational diseases, undocumented prisoners, overstayers of residence permits and unaccompanied children: entitled to the health package of the statutory health insurance system
Financing	Medication within the class "medicament à service medical rendu faible" only reimbursed by 15% Primary care: free of charge for UM with AME Ante and postnatal care: free of charge for UM with AME Specialists: free of charge for UM with AME (paramedical) secondary care: ? Hospitalization: free of charge for UM with AME Medication: reimbursement at 100%, 65% or 30% Additional care services: ? ➔ 100% free of charge with no pre-payment If no AME, payment of full costs for primary/secondary care, inpatient care and medicines. Emergency care is paid by fund "fonds de soins d'urgence" on case by case basis but is free of charge for UM.
Children	Immediately right to AME (only to proof identity)
Risk for expulsion	Non expulsion for medical reasons (if lack of treatment in country of origin could bring exceptionally serious consequences to the health condition)→ temporary residence permit for medical reasons or provisional authorization for medical treatment
Potential facilitators and barriers	Lack of knowledge of the law by public services and benefits agencies (especially in French overseas territories) and by health professionals Exclusion due to economic threshold (very low ceiling) People's ignorance of arrangements, language barriers, long delays



	PASS (24h healthcare clinics): (inappropriate) exclusion of persons without health coverage Higher % of children with no health coverage in comparison to adults Non expulsion for medical reasons: administrative failures, pressure on Préfets to meet targets for the numbers of illegal residents deported
References	http://vosdroits.service-public.fr/particuliers/F3079.xhtml Huma network, 2009 http://www.ameli.fr/assures/droits-et-demarches/par-situation-personnelle/vous-avez-des-difficultes/l-8217-aide-medicale-de-l-8217-etat/a-qui-s-adresse-l-ame.php Duguet 2011

Table 15 – Access to healthcare for undocumented migrants in Germany

Administrative procedure	Similar rights as asylum seekers who have been residing in G less than 48 months Every public administrative institution (also social welfare offices who are the competent authority to allow access and provide the Krankenschein) has the legal duty to denounce undocumented migrants to the Foreigners Office (not for health care providers and public hospitals) + penalization (Residence Act)
Conditions	Application for Krankenschein at the competent social welfare centre (recipient of the Asylum Seekers Benefits Act) (except in case of emergency)
duration	?
Health services	Medical or dental treatment in cases of serious illness or acute pain; medicines, dressing material and everything necessary for recovery, improvement or relief of illnesses and their consequences (incl HIV treatment and treatment of other infectious diseases); ante and postnatal care; vaccination; preventive medical tests; anonymous counselling and screening of infectious and sexually transmitted diseases HIV screening: access anonymous without particular conditions HIV and other infectious diseases treatment: after application for Krankenschein Primary care: after application for Krankenschein Ante and postnatal care: after application for Krankenschein + Dulding (see alternatives) Specialists: ? (paramedical) secondary care: after application for Krankenschein Hospitalization: after application for Krankenschein Medication: after application for Krankenschein + on presciption Additional care services:
alternatives	Local initiatives: Munich (medical contact point for uninsured people); Berlin Berlin (anonymous Krankenschein) Municipal or non-governmental medical offices: possibility to be treated free of charge and anonymously The Duldung (=temporary suspension of deportation): only possibility to receive care -->granted for 6 weeks before giving birth and 8 weeks after giving birth and on grounds of temporary impossibility of travelling deportation temporary suspended
Financing	Krankenschein paid by public funds



	HIV screening: free of charge in specific local centres HIV and other infectious diseases treatment: access free of charge only in cases of serious illness or acute pain and related to recovery, improvement or relief of illnesses and their consequences (HIV is considered serious illness or acute pain) Primary care: access free of charge only in cases of serious illness or acute pain and related to recovery, improvement or relief of illnesses and their consequences Ante and postnatal care: access free of charge paid with public funds Specialists: ? (paramedical) secondary care: access free of charge only in cases of serious illness or acute pain and related to recovery, improvement or relief of illnesses and their consequences Hospitalization: access free of charge only in cases of serious illness or acute pain and related to recovery, improvement or relief of illnesses and their consequences Medication: access free of charge only in cases of serious illness or acute pain and related to recovery, improvement or relief of illnesses and their consequences Additional care services:
Children	Same regulations as adults
Risk for expulsion	Duty to denounce undocumented migrants Duldung: temporary suspension of deportation for seriously ill persons (max 6 months). After 18 months they can apply for residence permit on humanitarian grounds. Residence permit in cases of hardship: for severely ill persons (max 3y) Residence permit on humanitarian grounds: for severely ill persons, deportation suspended for 18months à section 25(5), 25(4), 25(3) of the Residence Act
Potential facilitators and barriers	Central legal right to medical treatment under the Asylum Seekers Benefit Act but structural underprovision of health care due to the duty to denounce undocumented migrants Poverity of this group they cannot pay for treatment themselves depend on support to receive medical care Local initiatives often focused on target groups with specific problems (e.g. sex workers)
References	http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Dec/1650_Gray_hlt_care_undocumented_migrants_intl_brief.pdf

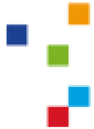


Table 16 – Access to healthcare for undocumented migrants in Malta

Administrative procedure	No legal or administrative provision, only a non-legally binding policy document (all foreigners in detention are entitled to free state medical care and services). No policy document for migrants in open centres other accommodation.
Conditions	Police number (in closed centres) or ID card (no rights attached)
duration	?
Health services	Standard health coverage (preventive, investigative, curative and rehabilitative services) for migrants in close centres. HIV screening: access anonymous and free of charge, no particular conditions required (same as nationals
alternatives	
Financing	
Reforms	
Children	Access to state medical care and services All children under 18 in need of care are allowed to apply for asylum and place under state custody. Non-legally binding policy document: same treatment as nationals
Risk for expulsion	No legal provision for reporting or denouncing to any immigration authorities. Non expulsion for medical reasons: 2 medical practitioners (one government medical officer), until 7th day after medical certificate. Residence permit for medical reasons: no legal provisions but in practice refugee commissioner could grant a temporary protection on humanitarian grounds.
Potential facilitators and barriers	All migrants detained systematically by arrival, detention for 1.5y. Children in same situation as parents. Lack of legislative framework, no adequate access to health care Access to health care in detention centres insufficient: shortage of practitioners, no bedside visit. Lack of coordination between hospital and detention centres No isolation of persons with contagious diseases or put in small cells (unhuman). In detention centres: no adequate shleters, lack of hygiene, overcrowded, no regular access to openair.
References	Huma Network, 2009

Table 17 – Access to healthcare for undocumented migrants in Portugal

Administrative procedure	More than 90days in P: access to all types of care, medication and tests - Document issued by local borough council + 2 witness declarations or signed statement --> Temporary registration as patients (access on single occasion + renewable) --> Pay moderating fee unless certificate from local borough council on lack of economic means Access to emergency care: care for diseases with compulsory notification, ante and post natal care, vaccination, family planning: free of charge Less than 90 days: care for diseases with compulsory notification, ante and post natal care, vaccination, family planning but fully charged for primary, secondary and emergency care (if no exemption due to economic situation)
Conditions	Prove of residence
duration	Single occasion but renewable
Health services	For UM residing in P for more than 90 days • All types of care, medication and tests • Access for a single occasion • If proof of lack of economic means, no copayment needed • Free of charge: emergency care, care for diseases of compulsory notification, ante and post natal care, vaccination, family planning For UM residing in P less than 90 days • Free of charge: care for diseases of compulsory notification, ante and post natal care, vaccination, family planning Full cost: primary, secondary and emergency care
alternatives	
Financing	
Reforms	
Children	Same as nationals (16y and younger) Registration neede by the High Commissioner for Immigration and Intercultural Dialogue (ACIDI)
Risk for expulsion	Residence permit for medical reasons (1y)
Potential facilitators and barriers	Complex administrative procedures General shortage of doctors and resources Overcrowding of emergency departments
References	Huma Network, 2009

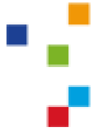


Table 18 – Access to healthcare for undocumented migrants in Sweden

Administrative procedure	Law 2013: 407 on healthcare to some foreigners who reside in Sweden without the necessary permits: - Obligation for the council to provide medical and dental care - Same regulations as defined in Health Care Act (1982:763) and Dental Act (1985:125) - Same access for UM children as nationals - For adults: care that cannot be postponed, maternal health, abortion care, contraceptive advice, medical examination - Medication: applies to drugs subject to Act 2002:160 on pharmaceutical benefits - Regional governments have the possibility to provide additional health services to UM - Free healthcare within Communicable Diseases Act Previous law (2008): UM not entitled to access health system unless they pay the full cost of health services even in emergency care.
Conditions	No need to prove identity
duration	?
Health services	Access to all types of healthcare services
alternatives	
Financing	Financed by county councils
Reforms	
Children	access to health care on same conditions as nationals
Risk for expulsion	
Potential facilitators and barriers	new law unknown by healthcare providers regional differences between counties
References	https://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2013407-om-halso--och-s_sfs-2013-407/?bet=2013:407 http://picum.org/it/attualita/bolletino/46726/#cat_25446 http://www.statskontoret.se/In-English/publications/2015---summaries-of-publications/care-for-undocumented-migrants.-a-follow-up-on-the-act-concerning-healthcare-for-people-residing-in-sweden-without-permission-201510/ http://sverigesradio.se/sida/artikel.aspx?programid=2054&artikel=6134440

Table 19 – Access to healthcare for undocumented migrants in UK

Administrative procedure	to be included in a NHS patient list by a general practitioner
Conditions	
duration	?
Health services	emergency care: immediately necessary treatment primary and secondary care: only free access to primary care, secondary care at full charge hospitalisation: access at full charge ante and post natal care: access at full charge (free care by midwives in community) medicines: same as nationals HIV screening: same as nationals HIV treatment: access at full charge treatment of other infectious diseases: same as nationals ➔ Access only if full costs are paid in advance if care need is considered as non-urgent
alternatives	
Financing	emergency care: free of charge primary and secondary care: only free access to primary care, secondary care at full charge hospitalisation: access at full charge ante and post natal care: access at full charge (free care by midwives in community) family planning: free of charge medicines: same as nationals HIV screening: same as nationals HIV treatment: access at full charge communicable diseases: free of charge
Reforms	
Children	only free access to primary care (if on list), emergency care, tretament of certain communicable diseases (except HIV) and mental health for severe cases
Risk for expulsion	duty of confidentiality is a legal obligation.
Potential facilitators and barriers	GPs can refuse to register someone refusal in secondary care is possible if UM cannot pay variety in policies between hospitals inpatient care after admission through emergency dept is fully charged to the UM
References	http://picum.org/en/news/blog/47606/ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implentatation_Plan_Phase_3.PDF

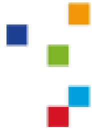
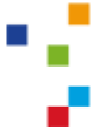


Table 20 – Access to healthcare for undocumented migrants in Spain

Administrative procedure	September 2012: free access to health care restricted to emergency, maternity and paediatric care. Other care services at full charge of UM. 2015: government will re-introduce the health card, which gives access to primary care Health card (DAS°: access to needed treatment without individual health card.
Conditions	Registration as resident of a municipality to obtain health card - Proof of residence (registration in local civil registry): valid passport - proof of habitual residence and renewed every 2 years - proof of lack of economic resources If not registered in a municipality: only emergency care free of charge
duration	Validity of 6 months (renewable for another 6 months).
Health services	emergency care: same as nationals primary and secondary healthcare: same as nationals (if individual health card obtained) hospitalisation: same as nationals (if individual health card obtained) ante and post natal care: same as nationals, no individual health card needed medicines: same as nationals (if individual health card obtained) HIV screening: same as nationals HIV treatment: same as nationals (if individual health card obtained), in some cases health care document possible treatment of other infectious diseases: same as nationals (if individual health card obtained), in some cases health care document possible
alternatives	some autonomous communities provide health care (solidarity card) without prior registration in town hall.
Financing	
Reforms	
Children	same as nationals (younger than 18y), no need to register to obtain individual health card
Risk for expulsion	
Potential facilitators and barriers	The police can access data of foreigners registered in town hall, this could influence the decision to apply for individual health card. Difficulties in complying with administrative requirements to obtain individual health card.
References	Huma Network, 2009

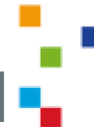
Table 21 – Access to healthcare for undocumented migrants in Italy

Administrative procedure	Access to National Health system if granted a STP code (Stranieri Temporamente Presenti-temporary residing foreigner code) STP card is delivered by local administrative district offices or dedicated offices in hospitals
Conditions	STP code: anonymous, free of charge Also have to apply for indigence status (stato di indigenza) declaring their precarious economic situation Valid form of identification
duration	6 months with possibility of renewal
Health services	Urgent care: with STP code Essential medical care (including continual treatment): with STP code but not possible to register with family doctor (needed for secondary care) + pay moderating fee Hospitalization: STP code + pay for moderating fee Preventive care Care provided for public health reasons (prenatal and maternity care, care for children, vaccinations, diagnosis and treatment of infectious diseases): STP code Medicines: STP code + cost of pharmaceuticals (0% A, 50% B, 100% C) Social protection for pregnancy and maternity on equal terms with Italian women
alternatives	If not enrolled in National Health Service: UM should pay tariffs set by the regions and autonomous provinces, except as provided for by international agreements signed by Italy in the field of healthcare. Always access to urgent medical care
Financing	STP code granted by local health administrations (Azienda Sanitaria Locale, ASL)
Reforms	
Children	STP code (similar to adults), no cost for pharmaceuticals
Risk for expulsion	Prohibited by law that health institutions and professionals denounce undocumented migrants to immigration authorities. Risk for expulsion: legal bases to protect seriously ill persons inasmuch as expulsion can entail irreparable harm to the health Unclear and insufficient legal regulation for the residence permit for humanitarian reasons
Potential facilitators and barriers	New decree from 2008 that they do not have to pay the ticket for any medical service: not known and largely unapplied Not possible to register with a family doctor but access to secondary care only if previously authorized by family doctor
References	http://www.aspag.it/index.php/english HUMA 2009 http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/illegally-resident/14a.italy_national_report_social_security_en_version.pdf



APPENDIX 12. STAKEHOLDERS CONSULTATION ON NEW SCENARIOS

Bottlenecks	Alternatives	Comments
Definition of DMH	• New name, same content (law of 1996)	**Stakeholdersgroup**: • OK, confusion exists and interpretation possible but change of name implies changing the RD **RIZIV/INAMI**: • OK, discussion on name in consensus with steering committee Witboek **CAAMI/HZIV:** • OK, but the content should also be defined • Couverture santé better name **POD MI/SPP IS:** • OK, but confusion with health insurance (for nationals) should be avoided • Couverture santé de base? **FOD VVVL/SPF SSE:** • OK **Steering Committee Witboek/Livre Blanc:** • Change of name could also have budgetary consequences **VVSG/AVCB:** • No specific comments **Medimmigrant:** • Name should not be changed, content remains the same • Preference for Fedasil-list
Criteria of social inquiry (territorialism, indigence)	• Within social inquiry only check of legal status (by CPAS – OCMW) • Automatic provision of personal, medical card for national territory	**Stakeholdersgroup**: • House visit not compulsory (omzendbrief 2014) but currently criteria not clear and changing over time→ risky for OCMW/CPAS – OCMW during evaluation by POD • Ok with limited social inquiry, but what is the role of the CPAS – OCMW? • Hof van Cassatie: UM do not have the automatic right on healthcare, a social inquiry is needed→ UMA not anymore in OCMW/CPAS – OCMW law but transfer to health insurance? • Magnet-effect? • Bxl: regional approach and collaboration needed instead of each community autonomously • How can OCMW/CPAS – OCMW take care of UM in other region of B?



- Medical card of 1y more feasible
- What if card is lost? (see problems with SIS-card)
- Indigence more complicated if UM lives together with persons with other status→ is not redundant

RIZIV/INAMI:

- Ok with restricted administrative procedure but CPAS – OCMW stays first contact point with UM for provision of medical card and societal integration
- Health system for UM should be similar to national health system
- Can UM be integrated in national health system as specific category (see art. 32, resident-regeling) without payment of contribution (will be in the future for different categories of nationals, without control of resources) + without free choice of sickness funds (only CAAMI/HZIV)
- Temporality is essential, restricted duration of medical card is needed (proposition in witboek is 3 months)

CAAMI/HZIV:

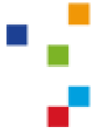
- Medical card more seen as proof of identity
- Picture necessary
- Role of OCMWs necessary to control legal status

POD MI/SPP IS:

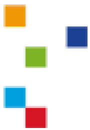
- No, (full) social inquiry is needed + no inclusion in national health insurance system. Some small steps can be propped to simplify the procedure but a total change of the current procedure would be too radical and would not be accepted on political level.
- Role of CPAS – OCMW: proximity to the UM→in centralized system: how to reach the UM+ who will perform the social inquiry? In other project already tried, but administration could not handle all these tasks
- Variety in practices between OCMW/CPAS – OCMW: big disadvantage of current system, more homogenous practice would increase equity between UM and versus nationals
- Social inquiry not the biggest problem but the differences in restriction on the rights on healthcare, set by the OCMW/CPAS – OCMW→ more objective criteria needed
- Social inquiry cannot be done by healthcare providers.
- Mediprima already first step in limiting the autonomy of the OCMW/CPAS – OCMW, by taking away the financial responsibility
- Social inquiry at which frequency: cost-efficiency?

FOD VVVL/SPF SSE:

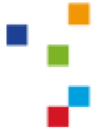
- Ok, but social inquiry is one of the obstacles, will leaving out this inquiry increase the number of applicants? Danger of magnet-effect?
- No control on indigence might not be accepted on political level



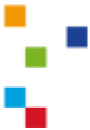
		• Simplification of procedure needed. Currently two risk factors: place of residence and voluntary of physician • Transfer of budget from POD towards FOD needed, UMA should be responsibility of FOD • Inclusion in budget B8 of hospitals? **Steering Committee Witboek/Livre Blanc:** • Control on place of residence needed to avoid medical shopping? • Preference for universal health coverage with acceptable access because of humanitarian and economic advantages **VVSG/AVCB:** • Role of OCMW/CPAS – OCMW in social inquiry? Who is financial responsible (now OCMW/CPAS – OCMW)? • Legal status now checked by OCMW/CPAS – OCMW and HZIV/CAAMI but final responsibility for OCMW/CPAS – OCMW→ should be changed • Lien de territorialité: OCMW/CPAS – OCMW has to verify if UM is not only “visiting” Belgium • House visit not compulsory but choice not to perform has to be justified for POD/SPP • Now: lack of objective, clear criteria by POD/SPP + financial responsibility for OCMW/CPAS – OCMW→ fear and extensive social inquiry • If territorialism is abandoned, better communication between OCMW/CPAS – OCMW needed to transfer files. Based on previous social inquiry, OCMW/CPAS – OCMW can decide whether or not to repeat social inquiry (or light version) **Medimmigrant:** • OK with proposition for social inquiry • Picture on medical card should not be a compulsory condition to obtain UMA • A lump sum per file should be provided by the SPP/POD to the OCMWs/CPAS – OCMW, but this demands an increase of annual budget • Duration of medical card could be prolonged to 1y • Why only renewal of medical card in OCMW/CPAS – OCMW and not in other organisations? • Transfer of information between OCMW/CPAS – OCMW needed to avoid redundancy but how in reality?
Medical certificate DMH/AMU	• Needs to be abandoned	**Stakeholdersgroup**: • No, is requested by politicians **RIZIV/INAMI**: • OK **CAAMI/HZIV:**



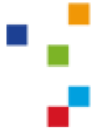
		• OK **POD MI/SPP IS:** • Ok, if package of care is clearly defined • Is a proof for public opinion that UM do not automatically have right on medical care • Suggestion: GP can also open the rights on healthcare? • Currently most critical point: more suggestions needed **FOD VVVL/SPF SSE:** • Ok • UMA should be linked to RIZV/INAMI + control by INAMI/RIZV **Steering Committee Witboek/Livre Blanc:** • OK **VVSG/AVCB:** • No specific comments **Medimmigrant:** • OK
Medical interventions covered by CPAS – OCMW	• RIZIV/INAMI nomenclature + additional list with medication? • Additional list approved by independent consultative physician • Co-payment equivalent to BIM and social MAF? • In accordance with consultative physician, reimbursement via BSF?	**Stakeholdersgroup**: • Ok with restricted list (similar to Fedasil). In Bxl already agree on reimbursement of D-medication. • The addition of interventions/medication is not fair relating to the nationals. • OK with co-payment but what if UM cannot pay? Case-by-case decision by OCMW/CPAS – OCMW? • Doubts on co-payments: feasible? • BIM and social MAF: reimbursement for the UM→ not feasible **RIZIV/INAMI**: • All interventions outside RIZIV nomenclature part of welfare regulation (bijstandregeling), so each OCMW/CPAS – OCMW can decide which interventions can be reimbursed→ OCMW/CPAS – OCMW can perform social inquiry • Option: Fedasil-list compulsory for OCMW/CPAS – OCMW. But: who should finance this, government or CPAS – OCMW? → check legal regulations • OK with co-payment equivalent to BIM and social MAF, threshold can even be decreased to 350euro (similar to chronic diseases) **CAAMI/HZIV:** • Now: choice of OCMW/CPAS – OCMW to pay additional costs, if reimbursement is restricted to RIZIV, will this lead to a restriction in practice?



		• Evaluation needed, similar to nationals. Now evaluation based on medical certificate and treatment plan, but physicians refuse to give medical information, so control is very difficult→ once access to healthcare, same regulations and conditions as for nationals • Automatic membership with CAAMI/HZIV (similar to 60y ago)? • BIM automatic or via social inquiry? How to control this? • No additional list nor additional procedure with approval by consultative physician **POD MI/SPP IS:** • Restricted list of interventions mentioned in coalition agreement (regeerakkoord)→ how to defence to public opinion that UM should have same access rights as nationals? • How is care defined in other countries? **FOD VVVL/SPF SSE:** • OK, but only RIZIV nomenclature code **Steering Committee Witboek/Livre Blanc:** • Additional list with D-medication needed **VVSG/AVCB:** • Who will pay additional costs if Fedasil-list is applied? • Consultative physician needed (linked to CAAMI/HZIV) **Medimmigrant:** • OK with Fedasil-list • No agreement on co-payment (but is already abandoned in updated version of scenarios)
Approval needed by OCMW/CPAS – OCMW needed to be referred to specialists	• GP may refer directly to specialists • UM cannot access directly specialists (difference with nationals)	**Stakeholdersgroup**: • OK, referral by GP needed to access specialist care • Which consequences if UM went directly to specialist? How to control? • Currently direct access possible for gynaecologists, paediatrics and dentists • Approval is redundant in mediprima **RIZIV/INAMI**: • OK, OCMW/CPAS – OCMW do not have to approve medical referral, so GP can refer directly to specialists • No direct access to specialists: no agreement. Why other system than for nationals? **CAAMI/HZIV:** • How to control this? Now bill of specialist without the notion of referral. • Restricted access to specialists: OK **POD MI/SPP IS:** • Approval needed, but can also be done by GP

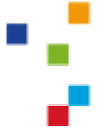


		FOD VVVL/SPF SSE: • How many UM directly to emergency care in hospitals (data available?)? **Steering Committee Witboek/Livre Blanc:** • Preference for soft referral-system • Harmonisation between OCMW/CPAS – OCMW needed **VVSG/AVCB:** • Ok **Medimmigrant:** • Ok, will be good practice but will be difficult in daily practice, e.g. UM on the move and consulting physicians in different cities + now difficult to change GMF
Lack of quality control	• A posteriori control by independent consultative physician (detection of outliers) • Role of mediator: UM can complain (law 2002)	**Stakeholdersgroup**: • Currently control on costs and social inquiry but no quality control **RIZIV/INAMI**: • OK, but should be identical to national health system **CAAMI/HZIV:** • Ok, identical to national health system • compulsory GMF **POD MI/SPP IS:** • currently parallel system RIZIV/INAMI vs POD MI/SPP IS, but no control performed by RIZIV/INAMI **FOD VVVL/SPF SSE:** • control should be performed by RIZV/INAMI **Steering Committee Witboek/Livre Blanc:** • control a posterior by RIZIV/INAMI possible **VVSG/AVCB:** • independent consultative physician needed for additional (or high) costs related to medical intervention **Medimmigrant:** • OK, no specific comments
Choice of healthcare provider often restricted	• Free choice of healthcare provider • Compulsory global medical file (different to nationals) • UM cannot access directly specialists (different to nationals)	**Stakeholdersgroup**: • Convention between physicians and OCMWs to facilitate communication (toetredingsovereenkomsten) but leads also to density with waiting lists and non-equal geographical distribution



		• Preference for free choice of HC providers **RIZIV/INAMI**: • OK, free choice of healthcare provider • No obligation to have GMF. What if UM refuses? • Proposition: automatic provision of medical card but GMF condition for prolongation of medical card • Which arguments for obligation? E.g. particular vulnerability→ list of all pro and contra arguments **CAAMI/HZIV:** • OK, free choice of healthcare provider • OK, compulsory GMF **POD MI/SPP IS:** • Maybe more restrictions needed than only GMF? • GP or OCMW should open the rights before consulting secondary care • Monthly feedback towards OCMW/CPAS – OCMW on consumption **FOD VVVL/SPF SSE:** • OK with three suggestions **Steering Committee Witboek/Livre Blanc:** • Ok, free choice of healthcare provider • Ok with referral system **VVSG/AVCB:** • Ok **Medimmigrant:** • OK
Information/cultural mediation not optimal	• Recognition/accreditation of intercultural mediation • Announcement on medical card	**Stakeholdersgroup**: • Should be part of basic training + sufficient incentives (software, budget for interpreters, info sessions etc) • GP and pharmacist should be mentioned on medical card **RIZIV/INAMI**: • OK, more details needed on which convention or accreditation **CAAMI/HZIV:** • OK, is really necessary **POD MI/SPP IS:** • No comments?

	FOD VVVL/SPF SSE: • MEM-TP project for healthcare providers • Should be included in basic training of each physician (compulsory internship) + accreditation→ focus on diversity and equity **Steering Committee Witboek/Livre Blanc:** • Should be added in basic training of each physician **VVSG/AVCB:** • No specific comments **Medimmigrant:** • No specific comments
	Additional comments **Stakeholdersgroup**: • If social inquiry is restricted, which role for OCMW/CPAS – OCMW? • Persons with tourist visa and with HC needs, will be automatically refused by OCMW/CPAS – OCMW **RIZIV/INAMI**: • This project can be part of “armoedeplan” (FOD/SPF) • Abandon criterion of territorialism also for homeless people **CAAMI/HZIV:** • Now: lack of control, more advantages for UM compared to nationals (not based on quantitative data) • Financing should come from RIZIV instead of POD **POD MI/SPP IS:** • No inclusion in national health insurance system, should be kept as a parallel system in POD MI/SPP IS **FOD VVVL/SPF SSE:** • Hospital law: art 110 and 116: government should pay for medical costs? • Interministerial conference on inequities • Transfer from POD to FOD **Steering Committee Witboek/Livre Blanc:** • Project FOD on intercultural mediation in firstline can be mentioned in report **VVSG/AVCB:** • 3 main concerns: medical tourism, medical shopping and responsibility for costs outside nomenclature



	• Other options: complete transfer to health insurance; operating budget per UM for OCMW/CPAS – OCMW **Medimmigrant:** • Fedasil-list: what is the experience of the physicians with this list? Are they pro or do they prefer the nomenclature list?