Intersectoral action for health in Belgium: a multi-level contribution to equity

Prof. Jan De Maeseneer, M.D., Ph.D.[1,2]
Leen De Roo, M.A.[1,2]
Bruno Art, M.D.,[1,3]
Sara Willems, M.A., Ph.D.[1]
Ilse Van de Geuchte, M.L.[1]

[1] Department of Family Medicine and Primary Health Care, Ghent University, Belgium.

[2] Community Health Centre Botermarkt – Ghent, Belgium.

[3] Community Health Centre "New Ghent", Belgium.

Correspondence to:
Prof. J. De Maeseneer
Department of Family Medicine and Primary Health Care
Ghent University
U.Z. – 1K3
De Pintelaan 185, B-9000 Ghent
Belgium
Phone: +32 9 240 35 42 +32 478 54 41 88
E-mail: Jan.DeMaeseneer@Ugent.be

CONTENTS

INTRODUCTION

This document reports a subjective perception of the developments in Belgium in relation to intersectoral action for health. It reflects the perspectives, analysis and conclusion of the authors, opportunity to be not only observers, but also actors in the different processes. When we use the term "multilevel" in this paper, we refer to the complex political structure of Belgium with federal, regional, provincial and local authorities. The study methods used are multiple: reports of our own experiences, literature search, study of policy documents. The inspiration for this paper comes from our daily commitment to more equity in health.

A. SUMMARY

In this case study we present how in Belgium, a federal state with policy-competences related to the social determinants of health distributed over 3 different levels (federal, regional, local), a set of actions have been developed gradually, contributing to more equity for health. This happened through an incremental approach, without a global comprehensive policy-framework. At the federal level, insurability of the population (with nowadays almost 100% cover) and access to health care have been improved through different measures. At the regional level, the "Local Social Policy" creates the framework in cities and villages for intersectoral action bringing together stakeholders from education, health, employment, environment, welfare,... At the level of the neighbourhoods, the bottom-up approach is illustrated. Different sectors meet regularly in local Platforms, facilitating action towards patients and towards the local community through networking. Primary health care facilities play an important role and are the starting point for a "Community Oriented Primary Care" strategy. Concrete examples illustrate how this strategy contributes to empowerment and integrates the different sectors in a continuous cycle: gathering information, making a "community diagnosis", planning actions and monitoring outcomes, involving in every step local community and stakeholders. Finally, the importance of universality (avoiding stigmatisation and dualisation) and the focus on the increase of "social cohesion" are stressed.

B. CONTEXT

1. What were the contextual factors at play?

Belgium is a small country with over 10 million inhabitants. It is a federal state consisting of a Flemish (Dutch speaking) region (almost 60% of the population), a Walloon French speaking region (40%) and the bilingual Brussels region (the capital). There is also a very small German speaking community. Political decisions are taken at different levels: at the federal (national) level, at the level of the regions, at the level of the 10 provinces, and at the level of local cities and villages.

Belgium spends about 9.3% of his GNP on health care (which is more or less the average of OECD-countries), and has a Bismarck-type insurance system, which covers almost 100% of the population[1]. Apart from the 72% of the expenses for health care that are insured publicly, 5% are insured privately, and the patients pay themselves 23% at the moment of service delivery. There is a huge health care supply with more than 1 physician for 250 inhabitants, and with high production-volumes (hospital beds, medical interventions, prescription of drugs, laboratory use,…). The dominant payment system in health care is fee-for-service.

The integration process of services in the welfare and health sector in Belgium, and particularly in Flanders, has been tackled in different ways and at different levels.[2] Administrative reforms, the promotion of mergers and cooperative ventures, and the decentralisation have been the most important procedures. The state reform of 1980 in Belgium led to a reorganisation of health and welfare. With this reform, policy competence for assistance to people was transferred to the Flemish and Walloon communities, so that the different activities in welfare (totally) and health care (partially) were decentralised. The social services were brought together in the Welfare, Public Health and Culture Department of the government of the Flemish Community. This ministerial department recognised and subsidised all of the welfare and some of the health services from 1980 onwards and is responsible for quality control. In 2005 the Flemish government created the Ministry for Welfare, Health and Family. Parallel processes took place in the Walloon region. The major problem, however, was that important parts of the responsibilities for health care policy remained at the Federal level: the complete curative sector, the financing of the hospitals, the criteria for planning of medical facilities, the price of drugs, … all this remained a competence of the federal government. Prevention, health promotion and mental health are the responsibility of the Flemish and Walloon region. This led to a disruptive situation were nowadays in Belgium at least 7 ministers, at different levels have competences related to health policy. The health sector was not the only one that was transferred (partially) to the regions: the same applies to traffic, employment, education, …

The composition of the Belgian population has changed a lot in the last 50 years: apart from the classic demographic transition, there have been 3 waves of immigration: the first one in the fifties and the sixties, mainly workforce for the mines (coming from Spain, Italy, …), workforce for the cotton industry and other industries in the seventies and eighties (mainly coming from Turkey and the Maghreb countries) and since the end of the twentieth century, globalisation is omnipresent and cultural diversity is a characteristic of most of the cities. Since 1980 the percentage of migrants in Belgium has stabilised at around 9% of the population. However, since 1992 a lot of foreigners have adapted the Belgian nationality, complicating the interpretation of figures.[3] Nowadays, the insertion of the young migrant population into the labour market through adequate education and training is one of the major challenges. The average level of education of children and adolescents from the migrant population is lower than the average Belgian level of education and this starts at the pre-school age.[4] This leads to more unemployment and low-status jobs, and inferior job conditions, and to socio-economic ethno-stratification. E.g. the average Belgian gains 96-95 € per day and the average 'new Belgian' 81-85 € per day. Non-EU migrants earn on the average 75-80 €.[5]

2. What was the nature of the public policy problem that intersectoral action was designed to address?

It was mainly the data on socio-economic differences in healthy life expectancy in Belgium (published in the media) that provoked the debate about equity and health in the political arena. Table 1 summarises the healthy life expectancy at the age of 25: the healthy life expectancy for men at the age of 25 is 28.1 years for those who have only primary school, and 45.9 for those who have higher education; for women it is 24.4 years for those with only primary school education and 49.1 years for those with higher education: a difference of almost 25 years.

Table 1: healthy life expectancy in Belgium at the age of 25, related to gender and educational level, 1991-1996/97 [6]

Educational level	Healthy life expectancy at the age of 25	
	Men (in years with CI)	**Women (in years with CI)**
Primary school or less	28.1 (23.6-32.6)	24.4 (19.8-29.0)
First cycle - secondary school	38.0 (35.4-40.5)	40.3 (37.7-42.8)
Second cycle - secondary school	42.6 (40.7-44.5)	46.5 (44.3-48.8)
Higher education (including university)	45.9 (44.3-47.5)	49.1 (46.6-51.6)

Although very impressive, this level of educational inequality in mortality is lower than the European average. Lower-than-average educational inequalities in mortality are also found in other Northern and Southern European populations, with the Basque Country having the lowest level. Higher-than-average educational inequalities in mortality are found in the East and Baltic regions.[7]

Apart from differences in healthy life expectancy, differences were consistently observed in objective and subjective health indicators in people living in deprived urban areas, as compared to the situation in the rest of the cities.[8] Such differences were documented for liver cirrhosis, lung cancer, depression, ischemic heart disease, …. As far as screening and prevention is concerned, there are clear indications for an "inverse care law".[9] the uptake of mammography in the framework of breast cancer screening is much higher in the higher socio-economical groups. The socio-economic differences start in early life: in 1995, babies in families with both parents unemployed had 1.58 times more chance to have a low birth weight, compared to the children with at least one parent working as employee. Social and ethnic differences are very often related: a study on social determinants of early childhood caries (at the age of 30 months) indicated ethnicity and deprivation-score of the neighbourhood as the two most important determinants of caries.[10]

The underlying mechanisms of those differences are complex: they are related to physical, psycho-social and cultural factors, employment, housing quality, environmental quality, … From research it becomes more and more clear that also the health care system contributes to social inequalities in health: people with lower education have problems with access. They tend to consult general practitioners, whereas higher educated people consult specialists.

Looking at those unhealthy social inequalities is a painful exercise for the eyes of politicians: there is an increasing awareness that something should be done in order to close the gap. And this should be done in a way that contributes to more social cohesion and avoids stigmatisation of certain groups in society (the poor, the ethnic minorities, …).

3. What policy objectives were identified?

As usual in Belgian policy, the problem was not tackled by a broad public debate in parliament, but put on the agenda by linkages between local initiatives, responsible researchers at university institutions (in departments of family medicine and health care, of public health and medical sociology), organisations like the King Baudouin Foundation[11] and initiatives of local health activists and civil society organisations e.g. self-organisations of the poor, representatives of ethnic minorities. A lot of those "linkages" developed

quite spontaneously: e.g. family physicians working in deprived areas that were involved in university departments brought the topic of 'health in equalities' on the research-agenda of the department. All these activities contributed to a "moment", rather than to a well-organised action-program. When analysing this movement the following shared objectives can be discerned:

- the need for the exploration of the causes of the differences in healthy life expectancy;
- an analysis of the contributions of the different sectors, including the health sector;
- the establishment of intersectoral action for health, overcoming the structural and administrative barriers of the political organisation of the State;
- the improvement of the health (care) system with a focus on high accessibility and quality.

Although the forthcoming description of the different approaches may give the impression of a coherent pre-established strategy, this was not the case. It was rather the result of a patchwork approach, where at different levels opportunities were taken by socially accountable stakeholders in order to tackle the problems of socio-economic inequalities in health. The goal to reduce health inequalities was certainly not explicit, especially because of the fact that in the last fifteen years, the growth of extreme right wing political parties made an explicit policy in favour of the poor and underserved and of ethnic minorities extremely difficult.

4. What were the origins of the policy?

The different approaches are merely the result of a bottom-up development. In the years after the may ’68 student revolution socially motivated family physicians, nurses, social workers, started to build community health centres in deprived areas of the cities integrating curative care, health promotion and patient empowerment. Initiatives were taken to reduce the out-of-pocket payments (normally 25% in Belgium). At universities, the study of poverty and its relationship with health became a topic for researchers and departments of public health and primary health care focussing on the exploration of mechanisms that contributed to social inequalities. Socio-cultural organisations, sickness funds, trade unions,… pointed at the problem of "health and poverty". There was an increasing self-organisation by people living in poverty, ethnic minorities, resulting in reports that described the living conditions from the perspective of the people involved.[12] Politicians, both at the federal and the local level, after “black Sunday” (the first victory of extreme right wing parties in the early nineties), started to subsidise projects for the improvement of housing conditions, living conditions, the creation of educational opportunities, … with a special focus on deprived areas. It was not a clearly established stepwise approach, but rather an incremental day by day pragmatic approach, that inspired development, very often starting at the local level. Although research funding was very limited, very regularly, articles and reports were published documenting the needs and the solutions that were locally adopted.[13]

C. APPROACHES

5. What was the nature of the intersectoral action in developing, implementing and or evaluating this policy?

Due to the complex distribution of the competencies of the governments at the different levels, it was not easy to establish a comprehensive policy-framework for intersectoral action. Just to illustrate: the financing of people that are unemployed is a federal issue, whereas the activation, training and orientation towards the labour-market of unemployed people are a responsibility of the regions; curative health care is

a responsibility of the federal government, whereas prevention and health promotion is a responsibility of the regions.

In order to harmonise policies, there is the mechanism of interministerial conferences, where representatives of the ministries at different levels are meeting to tune policies aiming at specific objectives. The Interministerial Conference for Social Integration (IMC) is a meeting of all the ministers who can take decisions concerning the combat against poverty, including health and welfare policies.[14] The impact of such conferences is rather limited. In the last decade however, the federal government has taken a lot of initiatives to improve access to the health care system: the requirements for "insurability" were simplified, facilitating the entry into the global health insurance system for almost the entire population. A mechanism was set up to protect families from large expenses out of their own pocket for health care: the "maximum bill". Once, in a certain year, the out of pocket payments of a family have reached a certain level (determined by the global income of that family), they have full reimbursement of all health care costs during that year. From the 1st of July 2007, the number of people having access to increased reimbursement for health care interventions increases, improving access especially for low income groups. The result is that nowadays Belgium has a health insurance system with almost universal coverage. Moreover since 1996, a royal decree gives access to "urgent medical care" for people living 'illegally' in Belgium, and this both for curative and preventive services.

Although there are regularly political discussions about "privatisation" of the health sector, until now, there is a societal consensus that solidarity should be the base of the system and that access to care is important. In 2006, the federal minister of health has created an "Impulseo-fund" to stimulate family physicians to establish their practices in deprived areas of the cities: this is a first attempt to orientate a quite liberal profession in a policy to address the problems of those most in need.

The Flemish government took the initiative in 2005 to establish a "Local Social Policy"-framework. The aim is the integration of welfare, health and equal opportunities - policy by the municipalities at the local level. The idea was that the highest possible accessibility of services provisioned to citizens should be achieved and that an effort should be made to optimise the weaker social groups and clients. The concept of the "Social House", would facilitate access for citizens with regard to social care provision. This should allow citizens to gain easier access to their social rights and to be helped in an effective way. In order to establish the Local Social Policy at the level of the cities and villages, a bottom-up approach was established. In the field, already in the eighties intersectoral initiatives were developed: the actual policy took advantage of this expertise.

In the city of Ghent (225.000 inhabitants) a process, directed by the Centre for Public Welfare of the city and the city-council, brought together 11 clusters, focussing on specific topics: the situation of the elderly, ethnic minorities, health care, housing quality, educative support, … In every group, both consumers and representatives of services participated together with researchers and representatives of policy departments of the city. In each of the clusters, priorities were formulated. All the priorities were brought together in a conference with the 11 clusters and finally 4 strategic objectives were formulated, the first priority aiming at accessibility of quality housing, the second focussing on an accessible and quality health care system. Then the 11 clusters worked on the formulation of concrete actions. In April 2007, these actions were prioritised, utilising an intersectoral approach, bringing people from different clusters together.

The result is a clear inventory of actions, aiming at reducing social inequalities and increasing social cohesion, involving different sectors: youth, housing, the elderly, disabled people, ethnic minorities, work, health, … In the forthcoming years, these actions will be put into practice, utilising a maximal bottom-up approach with high involvement of the target groups. Important strategic choices were made: inequality will be addressed by a universal approach, not by a categorical approach. This means that most of the

programs focus on the horizontal dimension, not the vertical one (the consequence is that there will be no "special services" for the poor, for ethnic minorities, but that e.g. family physicians and community health centres will be stimulated and helped to improve access to the health care system for vulnerable groups).

The locus of action will be as much as possible the 25 neighbourhoods in which the city of Ghent is divided, each of them looking after more or less 10.000 people. And also at the level of the neighbourhoods, an intersectoral approach will be developed (see point 6).

Important is that the whole process will be monitored, and that the city will invest in improving the databases on: employment, demographics, poverty. As far as health is concerned, every year one of the five most vulnerable neighbourhoods will participate in a health survey, so that relevant information is available on important indicators.

6. What mechanisms and tools were used to support intersectoral action?

In this part we will focus on the intersectoral action at the level of neighbourhoods. We will take as an example 2 neighbourhoods: "Ledeberg" and "New Ghent". Both of the neighbourhoods are characterised by high deprivation indices[15] and have a long history of bottom-up intersectoral initiatives.

A first prerequisite in order to establish intersectoral action at the local level is the creation of a Platform, where different stakeholders can meet. In Ledeberg the initiative was taken in 1986 by the Community Health Centre Botermarkt that experienced the need for networking and cooperation with the different health and welfare workers and other sectors at the community level. It was decided that the Platform with all the local health and welfare workers and other actors would meet 3-monthly. Till nowadays approximately 40 to 50 local stakeholders and workers (social welfare sector, child health department, street workers, police, representatives of Turkish community, employment services, school services,…) meet to exchange experiences and develop networking. The first aim of the Platform is getting to know each other and to learn more about each other's working field, goals, projects, … Moreover through information exchange the problems of accessibility of care for the local community become obvious and an inventory can be made of the most important problems. This leads to a community diagnosis dealing with issues such as poverty, traffic insecurity, quality of housing, loneliness,… The participants at the Platform commit themselves to an analysis of the problems and a search for locally shaped solutions, interacting with both the city administration and the target population. The Platform does not hesitate to confront local government with the problems, e.g. in the '80 there was a problem of access to welfare services, as all the services had left Ledeberg after the fusion of Ledeberg with the City of Ghent in 1977. In a public meeting in 1986, the needs and requests of the population were formulated to the local authorities, and in the forthcoming years an effort was made to re-open social services in Ledeberg. Very often, health and welfare workers act as "advocates" for the local population.

In the past 2 decades, the Platform has strengthened its expertise in tackling inequalities and poverty by organising training sessions, lunch debates, symposia,… that start from the experience and needs of local workers and try to put these in a broader societal context. In the recent years, the local government appreciated the importance of the Platform and supported it financially. Nowadays there are Platforms in every neighbourhood of the city.

Apart from networking, a highly accessibly comprehensive primary health care facility is needed. In 1978, the Community Health Centre started in Ledeberg, with the aim to provide comprehensive health services to the local community with a multidisciplinary team (family physicians, nurses, dentists, social workers, dieticians, health promoters,…). Originally, the health centre had to work in the system of the fee-for-

service, with 25% of co-payment by the patient. It became clear that this co-payment was a barrier to access care for large groups in the local community. Therefore negotiations were started at the national level to establish a capitation system with a patient list and no co-payments by the patients. In 1995, the Community Health Centre switched to this highly accessible form of primary health care delivery. Through the multidisciplinary approach, the social context of health problems and their relation with poverty could be explored and taken into account in patient care. Very often, thanks to the networking, the presentation of a health problem by the patient was a starting point to tackle inequalities: looking for better housing, empowering the skills of the patient, bringing patients with similar problems together in groups, working together with employment services,…

It became clear that an approach focusing on individuals and their families was not enough to tackle the causes of unhealthy inequalities, therefore, from the very beginning, a Community Oriented Primary Care strategy (COPC) was put in place.[16]

COPC is a way to integrate primary health care with public health-approaches. It consists of a systematic assessment of health care needs in the practice population, identification of community health problems, implementation of systematic interventions, involving the target population (e.g. modification of practice procedures, changes of life-style, improvement of living conditions) and monitoring of the impact of the changes to ensure that health services are improved and congruent with community needs. COPC-teams design specific interventions to address priority health problems. A team consisting of primary health care workers and community members assesses resources and develops strategic plans to deal with the problems that have been identified. COPC integrates individual and population based care, blending the clinical skills of the practitioner with epidemiology, preventive medicine and health promotion.

The process consists of: defining and characterising the community, identifying the community's health problems, putting priorities, developing interventions and monitoring impact. All the different stages require active involvement of the community.

Some illustrations of actions undertaken in Ledeberg by the Community Health Centre:

- **"Women living in poverty".** The starting point here was the fact that an increasing number of women consulted the health centre with psycho-social problems related to loneliness, lack of perspective, problems to educate their children,... it were al single mothers without formal employment. Together with the public welfare services, a project was started to interview these women, in order to investigate their needs and aspirations. The main topic that came up from these qualitative interviews was "loneliness", and the need for more social interaction. Therefore, an initiative was stared to bring together the women two afternoons in the week in order to discuss their situation, to prepare meals together, to exchange experiences,... The project used a stepwise approach: starting from rather modest objectives, trying to empower the women, and then preparing the next step. During the process (which is still going on) an increasing number of women felt sufficiently confident to go for a job. Nowadays, most of these women participate actively in a social employment project. It was very interesting to see how these women changed, not only at the psycho-social level, but even physically: the process of empowerment through group participation improved their health status considerably. In every phase of the project the women were involved to define the objectives and the strategies. The sectors of employment, education, housing and health, all contributed to this intersectoral COPC-approach.

- **Improving the physical condition of youngsters.** In the mid eighties it became clear in the consultations of the family physicians, that there was an increasing problem of physical fitness of the youngsters in the Ledeberg-community. A survey revealed that they spent twice as much time

(compared to the average Flemish youngster) in front of television and video and that they had much less physical activity. Discussions with the different actors made clear that the main problem was the lack of green spaces and play grounds in Ledeberg, where 10.000 people live on 1 km². With a group of volunteers, the Community Health Centre, started the construction of a playground and activities were organised during the holidays. It was a big success with almost 100 children participating in activities, half of them from the Turkish community and half of them Belgian children. The evaluation of the project indicated an increase in physical fitness, a decrease during the holidays of street criminality reported by the police, and more intercultural interaction between the Flemish and Turkish community.

- **Tackling "epidemics"**. Every year, the schools were confronted with lice-epidemics, in the young children. A thorough analysis of the problem was made, indicating that children from lower SES-families are particularly at risk of getting head lice[17]. A screening project, utilising wet-combing, was organised and information was given at different levels: schools, socio-cultural organisations, waiting rooms, public places,... For families with recurrent lice-infestations, special support teams with school nurses and primary care nurses, empowered the parents when caring for their children. A global strategic plan was developed, that was tested first in Ledeberg, later all over in the city of Ghent, and that nowadays acts as a guideline for the whole Flemish community (bottom-up approach).

- **Traffic safety**. The Community Health Centre was confronted with a lot of traffic accidents in front of the centre, with seriously injured victims. All stakeholders were brought together: organisations of the elderly, schools, police, experts in traffic safety, local inhabitants,... Together a plan for improving safety was discussed, taking into account the views of the different stakeholders. The final project was distributed in the neighbourhood and more than 500 citizens gave their feedback personally. All the suggestions were taken into account, and a final plan was put into practice, with emphasis on slowing down the traffic speed, safe places to cross the road,... Since that moment there are no more accidents with serious injuries.

- **Early childhood caries**. In the consultations of the family physicians and in the observation of the school nurses, it became clear that early childhood caries was an important problem for a lot of toddlers in the neighbourhood. Therefore a systematic screening was undertaken, revealing that 18% of the children at the age of 30 months had already symptoms of caries, especially children in the most deprived areas and children from ethnic minorities (especially Eastern Europe and Central Asia). None of the cases were treated. From the interviews with the parents it became clear that there was a lack of knowledge and also a problem of accessibility of dental care. Therefore, the Well Baby Clinics of the city of Ghent decided to do systematic screening for caries at the age of 30 months in the screening programme, and the Community Health Centre decided to create a highly accessible dental service, focusing at the most vulnerable groups and especially inviting children for the government's free dental care programme (up to the age of 12 years).

- **Access to care for illegal people**. Utilising the Belgian legislation for "urgent medical care" for people without papers, the Community Health Centre made an agreement with the public Welfare Service of the city of Ghent to facilitate care for illegal people in the health centre. Nowadays some hundreds of illegal people are treated in this and other Community Health Centres, both for preventive and curative services. The Community Health Centre also brought the needs for those people into the public debate on the definition of the scope of the medical care for the illegal people in the federal parliament (advocacy-role).

In all these actions different sectors (employment, health, traffic infrastructure, city administration, education,...) are involved. Thanks to the network in the Platform, this intersectoral cooperation is facilitated a lot.

In another neighbourhood, "New Ghent", a community health centre was integrated in the existing Community Welfare building, together with social services, a social restaurant, community development services, Well Baby Clinic,... The integration of the health centre in this multi-sectoral building, facilitates the possibilities of a comprehensive approach and the making of a "community diagnosis". From its start in 2000, the centre was involved in a qualitative study with focus groups on "New Ghent: healthy and fit?". The aim was to explore with different target groups (single parent families, immigrant families, single male inhabitants, ...) what their needs and expectations are in relation to health. Different programmes about healthy exercise, utilisation of medication,... were organised, involving different stakeholders (the local schools, the pharmacists, the social restaurant...).[18] In 2007 the theme 'healthy food' was partly set into action by students of the master in social work, who developed a 'healthy, cheap and multicultural cooking calendar' starting from recipes gathered in the local community.

Where the first three community health centres evolved from GP-surgeries in the 1970's, the next generation (2000) is being created following a more planned approach: the local government and the existing health centres join forces to answer the needs of the different neighbourhoods by starting new health centres.

Even typically difficult groups such as the homeless, benefit from the primary health care accessibility in Ghent. Although a recent study[19] shows that they are more burdened by disease than the average Flemish population, they appear to experience only minor problems with access to primary care, which is in contrast with the results of other studies. Part of these findings can be explained by the local intersectoral initiatives to maximise access to all inhabitants of a given neighbourhood.

7. Principal actors and their roles in the policy development implementation and evaluation

At the federal level the principal actors were the ministers of health and social security and the sickness funds, where there is a high consensus to develop and maintain the system based on solidarity. In the recent years, it becomes clear that the politicians try to have more impact on the delivery of health care, by formulating objectives and targets in terms of quality, accessibility and budget.

In line with the distribution of the political competences, the Flemish government tries to facilitate intersectoral cooperation in the field of welfare. The city of Ghent took fully the responsibility and local politicians supported strongly the implementation of the "Local Social Policy"-principles.

At the local level, stakeholders from different organisations and sectors, contributed to the realisation of the objectives, taking advantage of the facilitating measures put in place by the city administration (e.g. financial support, helping in the realisation of infrastructure, coordinating the data-collection). Finally local health care workers and services took their responsibility. University departments (Department of Family Medicine and Primary Health Care - Ghent University and Department of Public Health Ghent University) contributed to the data collection and analysis.

The most important strategies used were the following:

- **a territorial approach**: the local community and neighbourhood is the focus of action with a bottom-up perspective;

- **universality**: no selective approach with specific services for the poor or for the ethnic minorities. This leads to stigmatisation and dualisation, and is a real threat for social cohesion. In all the actions, the stakeholders tried to avoid creating a selective system for the poor.

- **comprehensiveness**: whenever approaching a problem, all dimensions should be taken into account: physical, environmental, psycho-social, cultural,... Comprehensiveness is a typical feature of the primary care approach, combining cure, care and prevention. Continuity of care is essential and contributes to cost-effectiveness[17.] Primary Health Care starts from the exploration of the expectations of the patient and the local population and focuses on the empowering of the individual health and strengths (health promotion), addresses individual and cultural norms and values, and takes, when needed, the advocacy role. Moreover, the primary health care team acts as a hub in the navigation of the patient in the health care system. Primary health care teams do not only address the needs of the individuals, but are also looking at the community, especially when addressing social determinants of health.

8. What were the outcomes?

Until now there are no systematic assessments of the outcomes of the different measures.

At the federal level, there are indications that the principle of the "maximum bill" is functioning adequately, but that it should be fine-tuned in order to really meet the needs of those most in need. It is clear that, for the most poor and deprived, any "out-of-pocket"-payment at the point of service delivery, may be a barrier to access health care.

As far as the "Local Social Policy" is concerned, the different cities and villages are now starting the process. At the process level, there are clear indicators that this approach has stimulated intersectoral cooperation between: employment, housing, health, education. Moreover, a comprehensive, universal approach towards vulnerable groups (disabled, young migrants,...) is developing. It is too early to assess outcomes of this approach. At the institutional level, it certainly has helped to create links between sectors that were working on their own in the past.

At the local level the effort to stimulate networking through a Platform in the neighbourhood, has positive results. A first result e.g. in Ledeberg is that, compared to 20 years ago, there is an increase of the quantity and quality of initiatives in the sectors of health and welfare. Nowadays the focus of the Platform has shifted from establishing new initiatives to facilitating the complementarity between existing initiatives, assuring that they reach the population in need and aiming at structural embedding of the different services. Of course there are always new challenges showing up (unemployment, multicultural society, changing family patterns,...). They are taken care for in a comprehensive approach. Moreover, the Platform is the place to be for new agencies and new professions in the neighbourhood, as it enables them to confront their objectives and strategies with other providers and stakeholders.

The COPC-strategy is continuously developing. There is clear progress in traffic safety, tackling the lice-epidemic, the problem of access of children to dental care. Moreover, thanks to a grant of the city, the community of Ledeberg has been selected to become a "city innovation area", which means that 25 million

Euros are available to change the infrastructure of the neighbourhood. This is an interactive process with intense community participation, and also participation of welfare and health services. Important objectives are: contribution of the infrastructure to "social cohesion" and intercultural interaction and intergenerational cooperation. A special focus in the project is on making the infrastructure (e.g. street-patterns, green spaces) so that physical activity is stimulated for the different age groups.

The health centre in "New Ghent" is now an established health service in the local community. The team is now investing more and more in community oriented action, putting into practice the conclusions of the explorative phase.

An important finding is that, through intersectoral cooperation, the subculture of the different sectors is challenged to change and become more open. It is not an easy process as e.g. for reasons of subsidies, each sector has to comply with specific requirements. And although authorities always state that "intersectoral cooperation is an added value", there are nowadays no clear incentives to stimulate and reward concrete intersectoral action. As an illustration: the subculture of the welfare-sector and the health sector is quite different, so misunderstandings and strategic discussions between both sectors are frequent. Another finding is that e.g. some politicians reduce the solution of the poverty problem to providing a job for everybody. They do not take into account that for some people with very limited skills (e.g. illiterate people, certain groups of disabled people, certain groups of chronic patients,...), the maximum that can be reached is a form of "social employment". So recently there has been an investment to start this kind of projects.

Nowadays, there are plans to assess the impact in a more systematic way, with the help of university departments.

9. What were the lessons learned?

We would like to summarise the lessons learned at the different levels:

- at a structural level: the complex distribution of political competencies (federal, regional, cities) hinders comprehensive intersectoral action. Sometimes the regulations are contradictory, or are addressing different territorial entities. So it is important that in a federal state, there is some tuning between federal and regional competencies, and at least there should be an agreement about the territorial entities that they are addressing.

- a strong public health insurance system, covering almost 100% of the population (including specific measures for illegal people), is an important asset for an accessible health care system. Any privatised system may create barriers and could lead to risk selection. Therefore the Belgian system, based on solidarity, creates opportunities to tackle socio-economic inequalities in health.

- although there is no formal policy addressing health inequalities, there are a lot of actions at different levels that contribute incrementally to health for the poor and underserved.

- the development of a policy is the result of different forces: initiatives of service providers, organisations of the poor, contributions from socially accountable university departments,... The example of the "Local Social Policy"-approach illustrates the strength of bottom-up strategies and creates intersectoral networking for health at the level of the cities and villages.

- a COPC-strategy embedded in a strong primary care system (e.g. with community health centres) is an efficient intersectoral approach in deprived areas. There is a need to stimulate these experiences and to start systematic research on process and outcome of this COPC-strategy.

- it is important to train workers in health care and welfare with the appropriate skills and attitudes. Early exposure to the social context of patients e.g. through community-oriented education is necessary.20 Skills in communication, interdisciplinary cooperation, change management, are of the utmost importance.

- as intersectoral action for health is a multilevel process, decentralisation is needed to incorporate local context adequately in the strategies. Moreover decentralisation increases ownership by the local community.

In figure 1[21] we illustrate the importance of a strong primary health care system as a strategy for promoting health equity and intersectoral action for health, including COPC-strategy.

Fig. 1: Primary health care as a strategy for promoting health equity and intersectoral action.

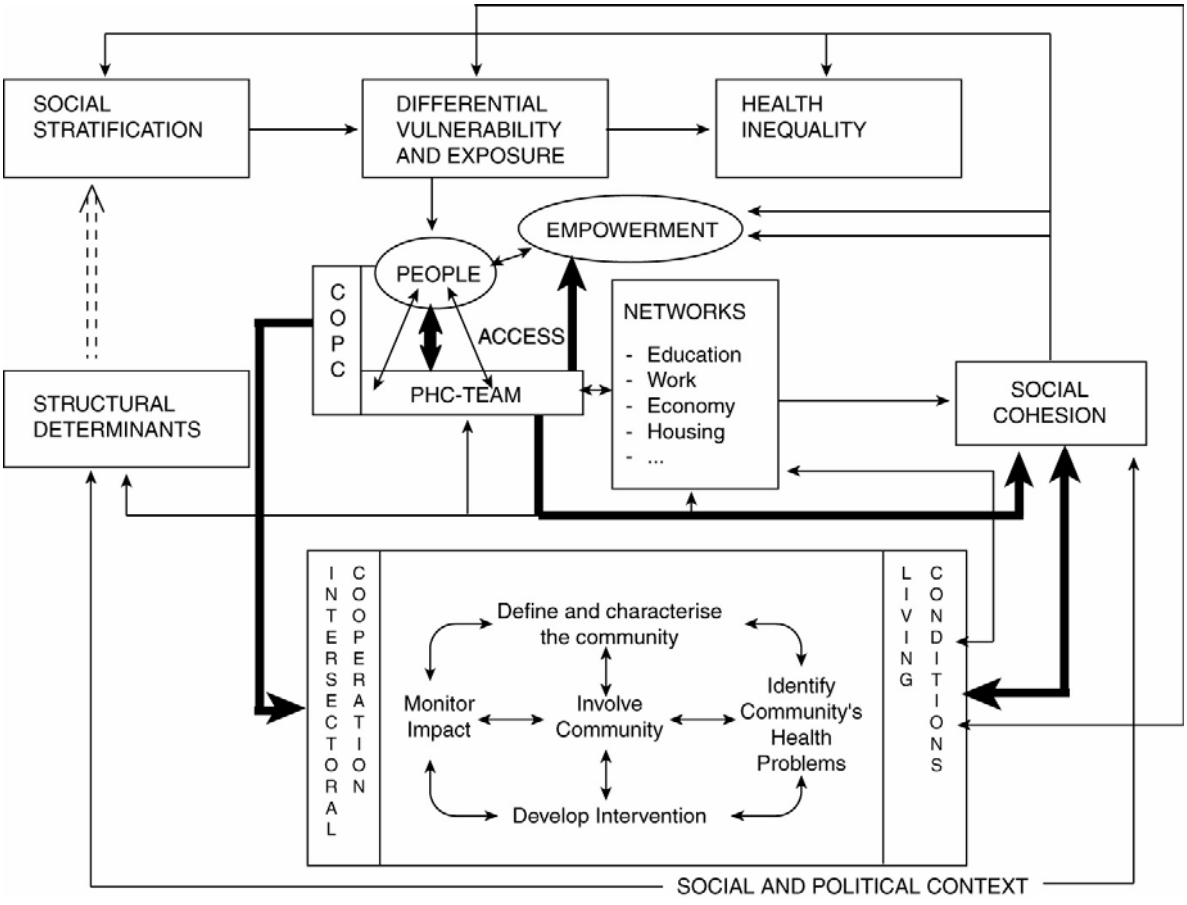

Figure 1 illustrates a hypothesis about how primary health care can be a strategy for promoting health equity and intersectoral action. A first prerequisite is a high level of accessibility of the primary health care team. A second is: the team should deliver a high quality care. Moreover, the team should interact with different networks (education, work, economy, housing,...) that are related to important sectors. Apart from an approach to individuals and families, the primary health care team should also address the community, utilising the COPC-strategy. The COPC-strategy, the direct action of the primary health care team towards the population and the intersectoral networking will enhance the social cohesion in the community. Both the actions of the primary health care team (curative, preventive) and the increased social cohesion in the community will lead to empowerment of the people. This empowerment is situated at different levels: physical, psychological, social and cultural. The empowerment of the population will decrease the vulnerability to factors that may contribute to health inequity. Moreover, as the COPC-action will address the living conditions of the local population, the exposure of the people to factors that may be a threat to their health will diminish and the differential vulnerability will decrease. Finally, a better education, better working conditions and decreased unemployment, better housing conditions, access to save food and water, will improve the structural determinants that influence the social stratification. In summary, the multidisciplinary primary health care team, operating in a network with other sectors will promote health equity through increased social cohesion and empowerment.

10. Applicability to other policy environments

The Belgian case can be inspiring for a lot of other countries, because many countries have a federal structure, with different levels of political competencies related to different sectors. Moreover, as in Belgium, in most of the countries there are no comprehensive explicit strategies addressing the social determinants of health, but the policy is rather the result of incremental actions.

The Belgian case illustrates how a multilevel contribution to equity can be made, stimulating intersectoral cooperation at macro-, meso- and micro-level. The complementarity of a top-down strategy (e.g. federal measures to increase insurability and accessibility of health care) and a bottom-up approach (intersectoral action at the local level involving local communities) create the necessary dynamics in order to keep the policy development at pace. Comprehensive primary health care services like the community health centres contributed to the development of intersectoral action for health. As illustrated in this case study, there is a need for improvement of data gathering and monitoring, in order to assess to what extend social determinants of health have been really influenced and health outcomes have been improved. Finally the importance of universality, avoiding dualisation and stigmatisation and the perspective of increased "social cohesion" have been stressed.

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