KEY DATA IN HEALTHCARE

COVID-19

period March 2020 - October 2022

Edition 2023

.be

Colophon

SUBJECT

In this publication, we decided to focus on the remits in which the Directorate-General Healthcare of the Federal Public Service Health, Food Chain Safety and Environment was actively involved during the pandemic. We provide an overview of the actions and initiatives in terms of organisation, financing and quality to which our service has contributed.

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www.health.belgium.be

Dépôt légal : D/2022/2196/45

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FOREWORD

Dear Reader,

I hereby present to you an updated version of 'Key data in healthcare – COVID-19'. Although we would have liked things to be different, the virus still impacts our lives. Once again, the colder autumn and winter months are giving rise to a surge in the number of infections and hospitalisations.

Behind the scenes, our services keep working to monitor this data and assist hospitals and care providers in the treatment of COVID-19 patients and the organisation of care.

In this edition, we have chosen once more to highlight a few activities in which our services within the Directorate-General Healthcare of the Federal Public Service Health, Food Chain Safety and Environment are closely involved. The sections relating to 'Organisation', 'Care activity', 'Funding' and 'Quality' from the previous edition have been included again and updated. In addition, in this edition some epidemiological data have been added, reflecting the characteristics of the COVID-19 patients admitted to the hospital in 2020.

I wish you a pleasant read,

Annick Poncé
Acting Director General, DG Healthcare

INTRODUCTION

The management of health crisis is an integral part of the basic remit of the Federal Public Service for Health, Safety of the Food Chain and the Environment (FPS-HSFCE). The FPS HSFCE is responsible for coordinating and implementing the integrated policy and management of health crises in cooperation with the various partners. What does this mean in the context of the COVID-19 crisis?

- The FPS HSFCE is closely monitoring the development of the pandemic, in order to propose the most appropriate measures to support political decisions to **protect** the population as a whole and stop or at least **limit the spread of the virus**;
- It is responsible for **the organisation and planning of care**, which includes psychosocial care as well as emergency assistance;
- The FPS HSFCE is responsible for the health **inspection of ships** and certain **airplanes** coming from risk areas;
- The FPS HSFCE is responsible for **the logistical and medical aspects of looking after Belgian nationals returning from abroad**;
- It is tasked with **informing healthcare professionals** about the risks of the virus and the measures to be taken if in doubt about infection;
- As a public service, the FPS HSFCE has the duty to **inform the public** as effectively as possible.

All these actions were implemented in cooperation with the partner organisations involved. In the current report, we opted to focus on actions in which the Directorate-General for Health Care of the FPS HSFCE was actively involved. The publication is divided into 4 chapters in which we elaborate on some of the above-mentioned tasks. In the chapter **'Organisation'**, an overview is given of the various consultation bodies and crisis units that were set up in the context of the COVID-19 pandemic. In addition, we describe some of the centres that were set up to deal with the COVID-19 crisis, as well as of some of the systems that were used to inform the public about COVID-19. The chapter **'Care activity'** summarises the actions taken by the Hospital & Transport Surge Capacity (HTSC) Committee. Several observations are presented on the impact of the pandemic on the emergency response. The chapters on **'Funding'** and **'Quality'** illustrate some of the initiatives taken during the pandemic in relation to these issues.

ORGANISATION

1. Consultative bodies and crisis units

On 12 March 2020, the federal phase of crisis management was declared in Belgium, meaning that from that point on, the COVID-19 pandemic was managed at national level. To this end, various consultation bodies were set up at national level, in which the different authorities and experts involved were represented. Within these bodies, various measures were drafted and taken to limit the spread of the virus.

1.1. Strategic and policy bodies

- The **National Security Council (NSC**) is a federal body consisting essentially of the Prime Minister and the Deputy Prime Ministers. In the context of the crisis, this body was extended to include the Ministers-President of the Regions and Communities. This collegial body took the policy decisions for the management of the crisis at the start of the pandemic.

- The **Consultative Committee** is a committee on which all governments and their Ministers-President – at federal, community and regional level – have a seat. Since the formation of the De Croo government (01/10/2020), the decisions concerning the COVID-19 pandemic have been taken here.

- The **Interministerial Conference (IMC) on Public Health** (see below).

- The **Federal Coordination Committee (COFECO**) is chaired by the National Crisis Center and is responsible for preparing the policy decisions of the Consultative Committee at strategic level, and for coordinating the implementation.

- The **Governmental Corona Commission** is responsible, among other things, for coordinating the communication between the federal government and the federated states as regards health policy. The Commission had to maintain relations with experts and social partners. In addition, the Commission was competent for formulating proposals for reforming the various consultation structures and thus simplifying the fight against the crisis. Finally, the Commission had to acquire new insights about the virus with a structured approach, and monitor the social, economic and societal impact of the measures taken. In this way, the Commission provided support for policy decisions and their implementation. The Commission's task was ended on 8 April 2022.

1.2. Scientific groups

- The **Risk Assessment Group (RAG)** analyses the risk to the population based on epidemiological and scientific data. The group is chaired by Sciensano and consists of experts from Sciensano, the federal and the regional health authorities, among others. Since November 2020, this body has taken over the remit of Celeval (see below) with regard to analysing epidemiological risks, and until 1 April submitted its opinions to the Governmental Corona Commission.

- The **Risk Management Group (RMG)** takes measures to protect public health based on the advice of the RAG. This group is chaired by the FPS Health, Food Chain Safety and Environment (FPS-HSFCE) and consists of representatives of the health authorities, both federal and federated. As an extension of this, the Hospital Transport & Surge Capacity Committee and the Primary & Outpatient Care Capacity Committee were set up (see below).

- The **Scientific Committee Coronavirus** provides scientific advice on the evolution of the virus.

- The **'Evaluation unit' (Celeval)** consisted of various experts who initially combined the advice of the RAG, the RMG and the Scientific Committee. On this basis, the unit advised the authorities on measures to be taken to stop the spread of the COVID-19 virus. At the end of August 2020, the composition of Celeval was expanded to include experts from various sectors, and the unit took over the task of the GEES (see below). The Evaluation unit was dissolved at the end of November 2020. On the one hand, Celeval's remit was transferred to the RAG and the FPS-HSFCE. On the other hand, it was decided to set up ad-hoc advisory groups for specific advice or strategic policy questions, since this exceeds the RAG's remit.

- The **'Group of Experts tasked with the Exit Strategy' (GEES)** was a group of 10 experts tasked with providing advice to restart public and economic life after the first wave and stop the spread of the COVID-19 virus. This group was wound down in August 2020.

- The **'Expert Committee on Management Strategy'** or **'Group of Experts for the COVID-19 Management Strategy' (GEMS)** was set up in December 2020 as the successor to Celeval and GEES, and provides advice on the crisis management measures. Together with the Governmental Corona Commission, they ended their activities on 8 April 2022.

1.3. Operational crisis units

Various crisis units were set up to operationalise the crisis management:

- The **Operational unit** is coordinated by the National Crisis Center (NCCN). This unit is responsible for alerting the various crisis units, monitors their operations and also has the objective of facilitating the flow of information between the various authorities involved.

- The **Socio-economic unit** provides advice on the socio-economic impact of the measures taken or to be taken.

- The **'Economic Risk Management Group' (ERMG)** is responsible for managing the economic and macro-economic risks relating to the spread of the COVID-19 virus in Belgium.

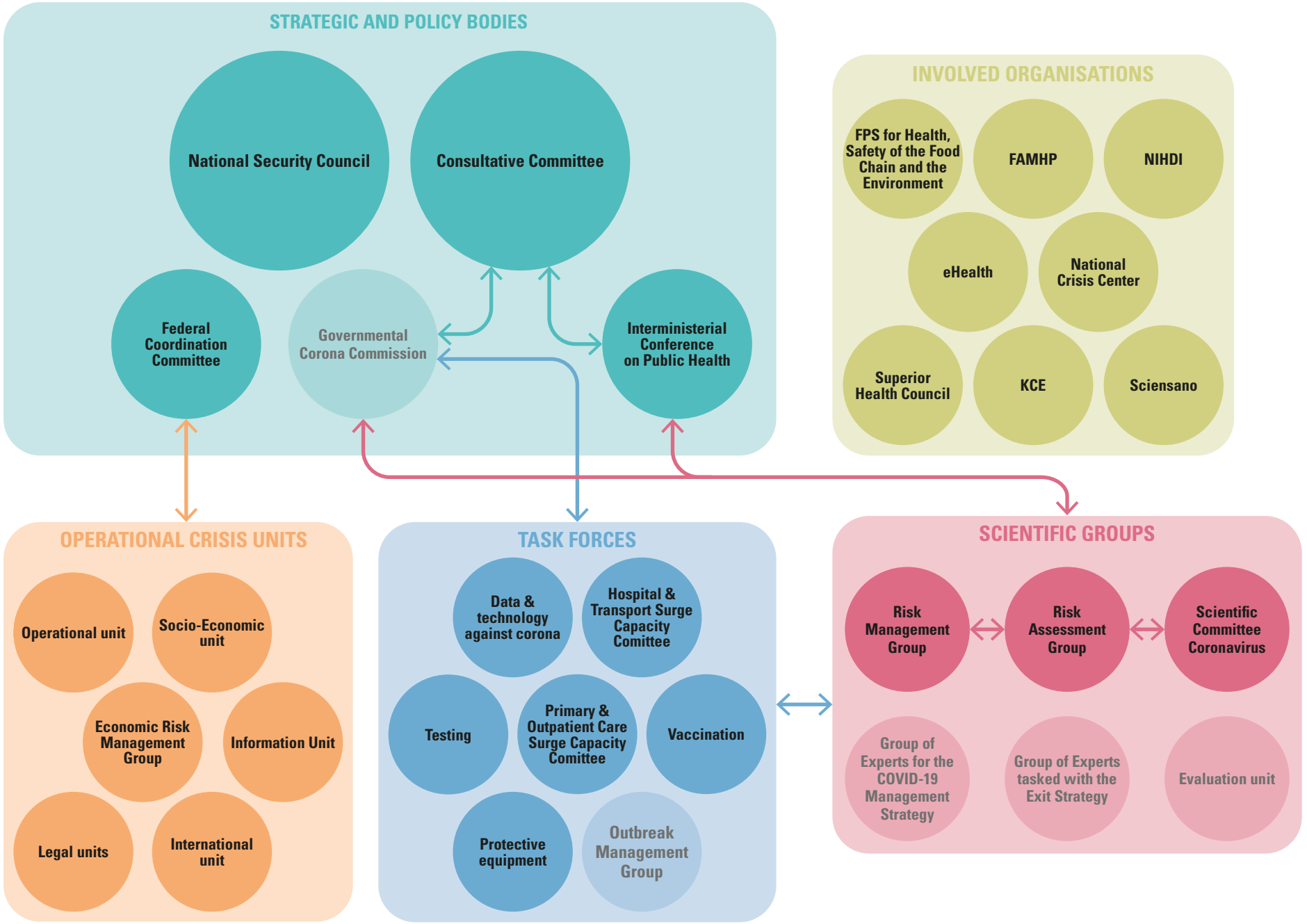
- The **Information unit (INFOCEL)** is co-chaired by the FPS-HSFCE and the NCCN. This unit is responsible for consistent communication to the public with regard to the pandemic.

- The **Legal units** are responsible for drafting legal texts and answers to numerous legal questions raised in the context of this complex crisis management.

- The **International unit** is responsible for a smooth flow of information between the equivalent authorities on crisis management within Europe.

- In addition, **various task forces** were set up on specific topics (e.g. regarding testing, vaccination, personal protective equipment, data (e.g. data technology against coronavirus) to fight the pandemic.

CONSULTATIVE BODIES AND CRISIS UNITS



1.4. Consultative bodies in the spotlight

In this report, we opted to take a closer look at the operations of four consultative bodies:

HOSPITAL & TRANSPORT SURGE CAPACITY COMMITTEE

The Hospital & Transport Surge Capacity Committee (HTSC Committee) is tasked, on the one hand, with monitoring the number and nature of COVID-19 patients in general hospitals and university hospitals. On the other hand, the Committee needs to address issues of capacity and flow of patients in hospitals. The Committee also oversees the organisation of (non-)urgent transport for patients. The members of the Committee formulate advice on the aforementioned subjects to the RMG. Among other things, the HTSC Committee drew up a phasing plan to ensure sufficient hospital beds and resources within hospitals for patients with COVID-19. It also drew up a distribution plan for patients and conducted analyses in the context of postponing non-essential care. The Committee is coordinated by the Directorate-General Healthcare of the FPS-HSFCE. The Committee focuses on inter-federal cooperation to provide streamlined communication and approaches.

In the spring of 2022, the HTSC Committee saw the number of hospitalisations of COVID-19 patients in intensive care and nursing units decrease further. The distribution plan could therefore be phased out. The Committee found that during the pandemic hospitals got organised to treat COVID-19 patients. If necessary, problems will be anticipated in due time. The members of the Committee are of the opinion that hospitals can take on greater responsibility in the organisation of COVID-19 care at their institution and within their network. If desired, the hospital can turn to the phasing plan to ensure that it always keeps sufficient beds and resources available for COVID-19 patients.

The Committee, in addition to its task of monitoring the occupancy rate for COVID-19 patients within the general and university hospitals, has taken on an additional task. Shortly after the start of the war in Ukraine, a European evacuation mechanism was established for patients needing care. Given (i) the interfederal cooperation, (ii) the representation of the hospitals by the umbrella organisations, and (iii) the contacts with professional associations through an extensive network, the HTSC Committee is the ideal platform to map the care offer. In the meantime, this has ensured the smooth repatriation and hospitalisation of various Ukrainian patients.

Find out more about the HTSC Committee:

consultativebodies.health.belgium.be

PRIMARY & OUTPATIENT CARE SURGE CAPACITY COMMITTEE

The Primary & Outpatient Care Surge Capacity Committee (POCSC Committee) was set up at the request of the RMG to complement the work of the HTSC Committee. To relieve hospitals as much as possible, the optimal organisation of primary care was essential. The POCSC Committee examines the organisation and availability of care outside the hospital and transmits its advice to the RMG. The federal government, the various regional authorities and representatives of general practitioners form the basis of this Committee. Depending on the topics to be discussed, representatives from home care, hospitals, residential facilities or associations working on behalf of the

most disadvantaged are involved. The Committee must ensure that primary care, hospital care and new forms of care (e.g. telemonitoring, triage centres) are coordinated and appropriate.

Over the past two years, various matters have been dealt with, including:

- the organisation of testing in schools and companies;
- the reduction of the high workload for general practitioners;
- explanation of the financing of the alternative centres ('test villages');
- advice on the testing strategy to take some of the load from primary health care, for example by testing only symptomatic patients.

OUTBREAK MANAGEMENT GROUP (OMG)

At the request of the RMG, the Outbreak Management Group (OMG) was set up on 23 March 2020. This working group formulated advice on how to handle the COVID-19 measures and contamination in residential organisations, such as assisted living facilities, institutions for people with a disability and reception centres for migrants.

The first objective of this working group was to make a joint analysis of the situation in the afore-mentioned institutions based on the various data available within the regional authorities. The second objective was to support the regional authorities in elaborating the decisions taken at the National Security Council or subsequently the Consultative Committee. These decisions needed to be translated into the context of residential institutions, and especially assisted living facilities, as these were the most affected. Among other things, the OMG formulated advice on the following questions: 'How should the limited available protection equipment be used?', 'How can the limited number of staff be deployed?', 'Why and in what way can one or more people be isolated from other people?'. This advice led to 'mobile teams' being set up, consisting of healthcare professionals, who assist the residential institutions with advice and identify the strengths and development points of an organisation. The aim is to support them in preparing for new waves of infection.

In October 2020, it was decided to wind down the OMG, as the cooperation had enabled the regional authorities to organise themselves autonomously and efficiently to respond to the pandemic in residential institutions. The positive collaboration of the OMG led to a pilot project being set up called the Hospital Outbreak Support Team (see chapter on 'Quality').

INTERMINISTERIAL CONFERENCE ON PUBLIC HEALTH

The Interministerial Conference (IMC) on Public Health is a consultative and decision-making body involving all competent ministers for public health in our country. The IMC's main objective is to ensure and encourage consultation and cooperation between the federal government and the federated states.

The IMC continued its coordinating role and the validation of the measures taken in the context of health unabated. During various consultation moments, they share information and take decisions on the following subjects:

- the evolution of the pandemic and the state of affairs of the vaccination campaign;
- the strategy on pandemic management (to be able to guarantee better preparedness for a possible future crisis);
- the development of a mid/long-term strategy on testing and detecting infections, as well as isolation and quarantine measures.

To find out more about the remit of the Interministerial Conference on Public Health:

consultativebodies.health.belgium.be

2. Centres set up to control the COVID-19 pandemic

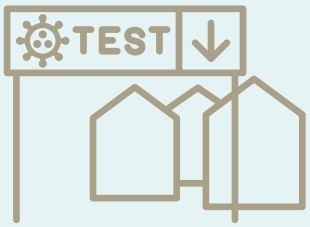
Several centres were set up in the context of the COVID-19 pandemic. The triage and testing centres and the 'transitional care' centres are discussed below.

2.1. Triage and testing centres

The triage and testing centres have a dual function[1]:

- The **triage function** is intended to prevent emergency departments from being unnecessarily overwhelmed and to prevent too many potentially infected patients from showing up at the general practitioner (GP) for a consultation. By setting up triage centres, the aim was to reduce the risk of spreading the COVID-19 virus. The patient is initially examined by a doctor, who determines whether a referral to the emergency department is necessary or whether the patient may be allowed to recover at home, possibly after a COVID-19 test. This is organised by the GP groups in close cooperation with the emergency services and can, under certain conditions, be (temporarily) stopped when the need subsides.

- The **testing role** was assigned to the centres as a second function to better meet the needs of population screening. Indeed, it must be possible to meet the demand for testing for any person who meets the predefined testing criteria. These include symptomatic individuals as well as asymptomatic individuals who have had a high-risk contact or who have returned from a red zone. Due to the easing of the measures for travel abroad, the centres have been requested to test travellers.



139 triage and testing centres have been set up and an **alternative testing centre** or **test village** has been set up in **12 locations**[2].

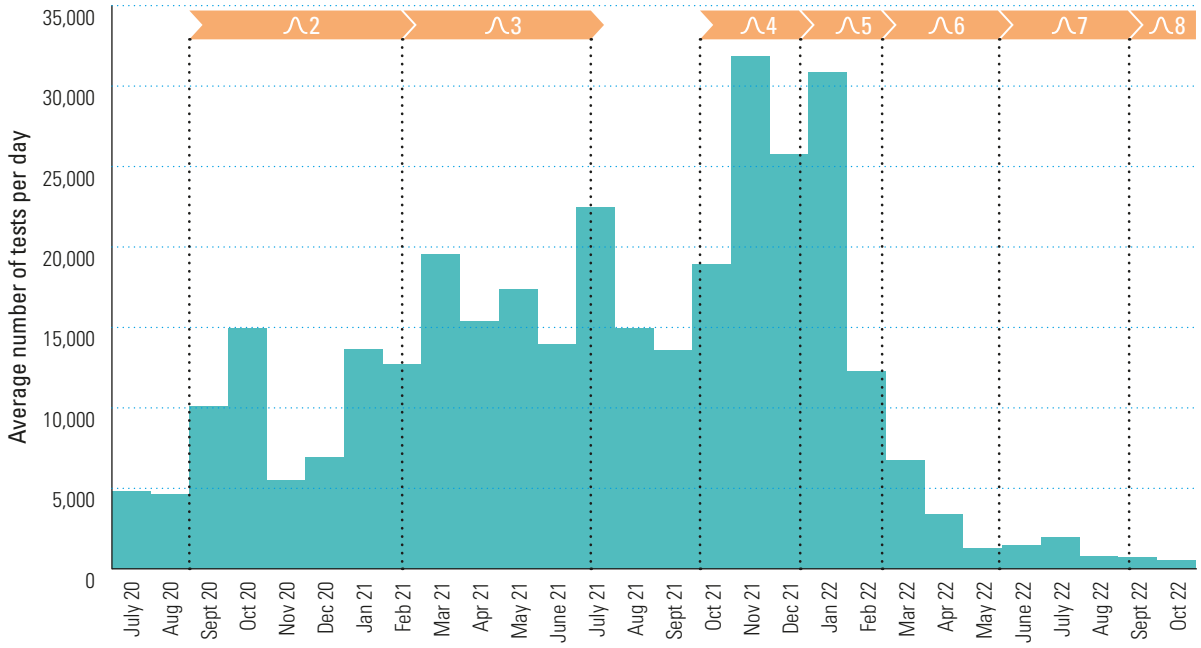
One centre per 100,000 inhabitants has been set up, with medical coordination being entrusted to a GP group (i.e. an association of representatives of GPs within a specific region). The triage is located in one site, but the testing can be organised in different locations to make both the testing and screening more accessible.

1 Source: Royal Decree of 13/05/2020 No 20 on temporary measures in the fight against the COVID-19 pandemic and to ensure continuity of care in compulsory medical care insurance.

2 Source: DG Health Care, FPS HSFCE (31/10/2022)

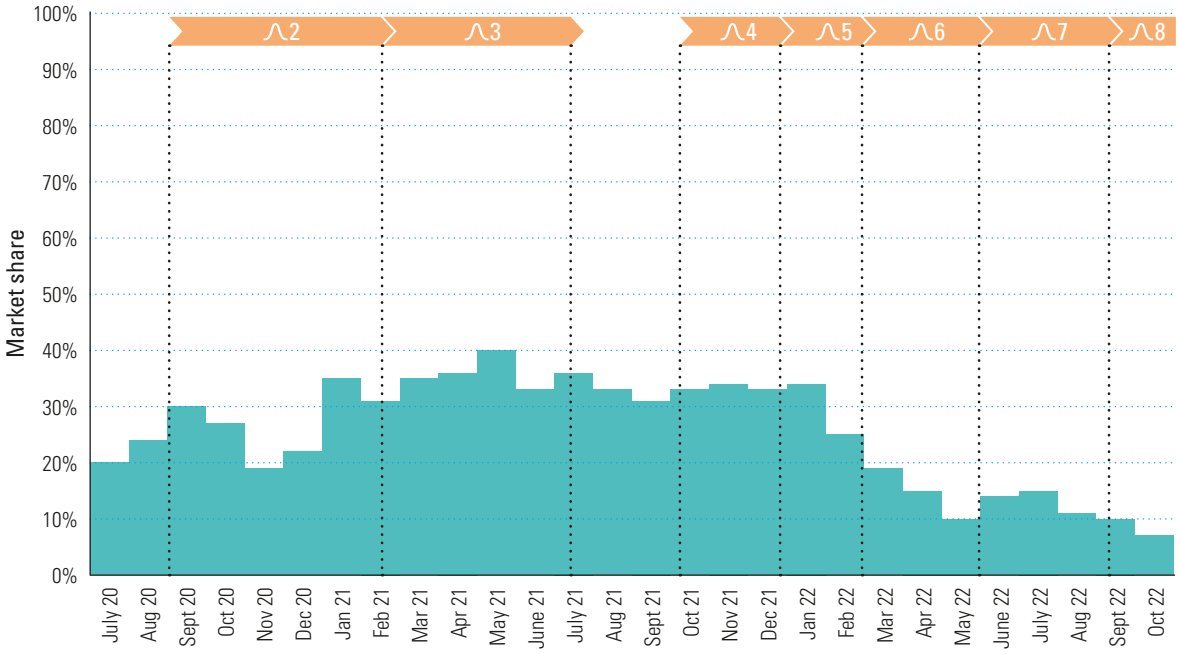
As the epidemiological situation became more favourable, the number of centres were reduced. Activity at the centres was highest between November 2021 and January 2022. About 100 centres were active during this period, running an average of 29,532 tests per day. This corresponds to one-third of all tests performed (34%) during this period. Between July and October 2022, the 33 active centres averaged 1,001 tests per day. This represents around 10% of all tests performed during this period.

AVERAGE NUMBER OF TESTS TAKEN PER DAY IN TRIAGE AND TESTING CENTRES (INCLUDING TEST VILLAGES)



The graphic above shows the average number of tests per day in the triage and testing centres and the testing villages. Most of the tests were taken during wave 4 and wave 5. The reason for this lies in the fact that the testing capacity was at the maximum at these times. In addition, the Omicron variant – which dominated in wave 5 – was very contagious. As a result, more people were infected with COVID-19 and more tests were taken. Unlike in other waves, no restrictions were imposed at these times regarding which individuals were tested. Both symptomatic individuals and asymptomatic individuals with high-risk contacts were systematically tested. We also saw an increase in the number of tests taken in waves 2 and 3. In addition, we saw an increase in the number of tests taken in the summer of 2021 as a result of passenger testing. Since February 2022, we have observed a sharp decline in the number of tests taken at testing centres.

MARKET SHARE OF TRIAGE AND TESTING CENTRES
(INCLUDING TEST VILLAGES)



The graphic above shows the proportion of tests in triage and testing centres compared to the total number of tests taken in Belgium. We see that this proportion varies between 10% and 40%. The average market share for the period 29/7/2020 to 31/10/2022 is 26%. In addition, we note that the proportion is higher on Mondays, Sundays and public holidays. This is partly because many people wait until after the weekend to consult their doctor and consequently get a referral for a test on Monday. The reason for a greater market share on Sundays and public holidays is because there is less or no testing at that time in other places (e.g. GP and hospitals).

Find out more about the locations of triage and testing centres:

doclr - Covid test

To ensure sufficient capacity for analysing samples and test materials, a federal platform was set up in addition to the conventional testing circuit, organised in and by clinical laboratories. The federal platform is responsible for supplying test equipment, collecting and transporting the tests to the laboratories and forwarding the test results. A total of 63 out of 139 triage and testing centres and alternative testing centres used this platform. The other centres work with a hospital laboratory or a private laboratory. In such cases, the laboratories themselves are responsible for supplying test equipment, transporting the tests performed and forwarding the results. A centre can switch to the federal platform if the laboratory is no longer able to complete the analysis of the tests within the predetermined time frame or if the demand for analysis exceeds the laboratory's capacity. Once a centre has switched to the federal platform, this cooperation will continue as long as the capacity of the conventional circuits is exceeded.

You can find out more about the current procedure for when you have to be tested and where this can be done at

www.info-coronavirus.be

2.2. 'Transitional care' centres

A transitional care centre formed a 'link' (an intermediate step) between the hospital and a return to living independently[3]. These centres were set up to maintain sufficient capacity in the hospitals. The transitional care centres provided support to patients testing positive for COVID-19. The patients in these centres:

- were previously hospitalised;
- or were previously examined in a triage and testing centre or an emergency department where it was decided that admission to hospital was not necessary.

However, these patients were either found to be unable to comply with the strict rules of isolation, hygiene and keeping away from high-risk individuals when they would return to their normal living situation. Or these patients still needed specific care. For these reasons, they could be admitted to a transitional care centre for a stay of up to three weeks. There, they could recover and receive the necessary care and support before returning home.

The transitional care centres were staffed by (general) practitioners, nurses and healthcare assistants, and financed by the National Institute for Health and Disability Insurance (NIHDI). The federated states were responsible for providing the necessary additional support. To this end, they developed partnerships with the social services of the municipalities or the 'Social Work' departments of various health insurance funds.

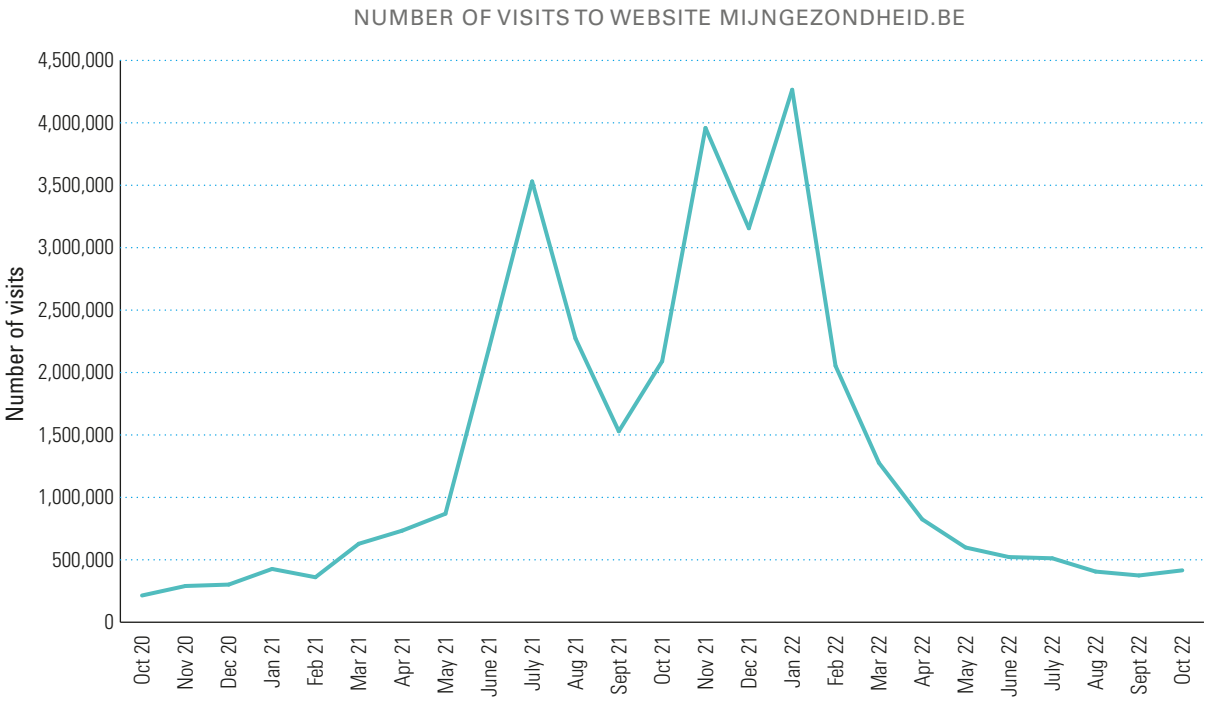
In the period from 2 April 2020 to 30 May 2021 a total of 18 transitional care centres were opened. These 18 centres received 605 patients (476 in Flanders and 129 in Wallonia). The operation differed in duration of the opening period of the centres, but also in number of patients. Some centres only treated 4 or 5 patients, while one centre received 123 patients. The activity of the centres was concentrated in two periods: from April to May 2020, and from November 2020 to May 2021.

3 Source: Royal Decree of 13/05/2020 No 20 on temporary measures in the fight against the COVID-19 pandemic and to ensure continuity of care in compulsory medical care insurance.

3. Online health website mijngezondheid.be

Since the launch of the **COVID-19 section** on the **mijngezondheid.be** website, it has been visited **more than 33 million times**.

The graphic below shows some peaks in website visits. On the one hand, these peaks are related to new functionalities on the website such as consulting test results, requesting a PCR test, requesting the EU digital COVID certificate, and others. On the other hand, these peaks relate to the COVID-19 waves.



In January 2022, the average number of daily visitors increased to ± 58,000 compared with ± 7,000 daily visits in January 2021.

Some improvements have already been integrated into the website:

- the COVID-19 sections were organised into 4 key themes for easy retrieval of information:
  - Testing and results
  - Self-isolation
  - Vaccination
  - EU Digital Covid Certificates

- The Frequently Asked Questions section was further updated to better meet the needs of citizens.

4. Maintaining capacity within general and university hospitals

In mid-March 2020, when it was confirmed that the influx of patients with COVID-19 into hospitals was increasing exponentially, the HTSC Committee (see above) took action by issuing national guidelines to general and university hospitals at regular intervals.

The general and university hospitals were called upon to show solidarity and take responsibility by adopting the necessary measures to treat a maximum number of patients with COVID-19 infection according to their capacity and expertise. The hospitals were also asked to make arrangements within their networks to work together to deal with the influx of patients.

A daily overview of the number of admissions was needed in order to effectively monitor the situation in the Belgian hospitals. The hospitals registered the admission data and the available capacity via the Sciensano apps and via the Incident & Crisis Management System safety website respectively. On this basis, visual, dynamic dashboards were created to support the policy decisions.

4.1. Distribution plan

The HTSC Committee drew up a distribution plan during the first COVID-19 wave with the aim of providing clear guidelines to hospitals to ensure sufficient hospital capacity during subsequent waves.

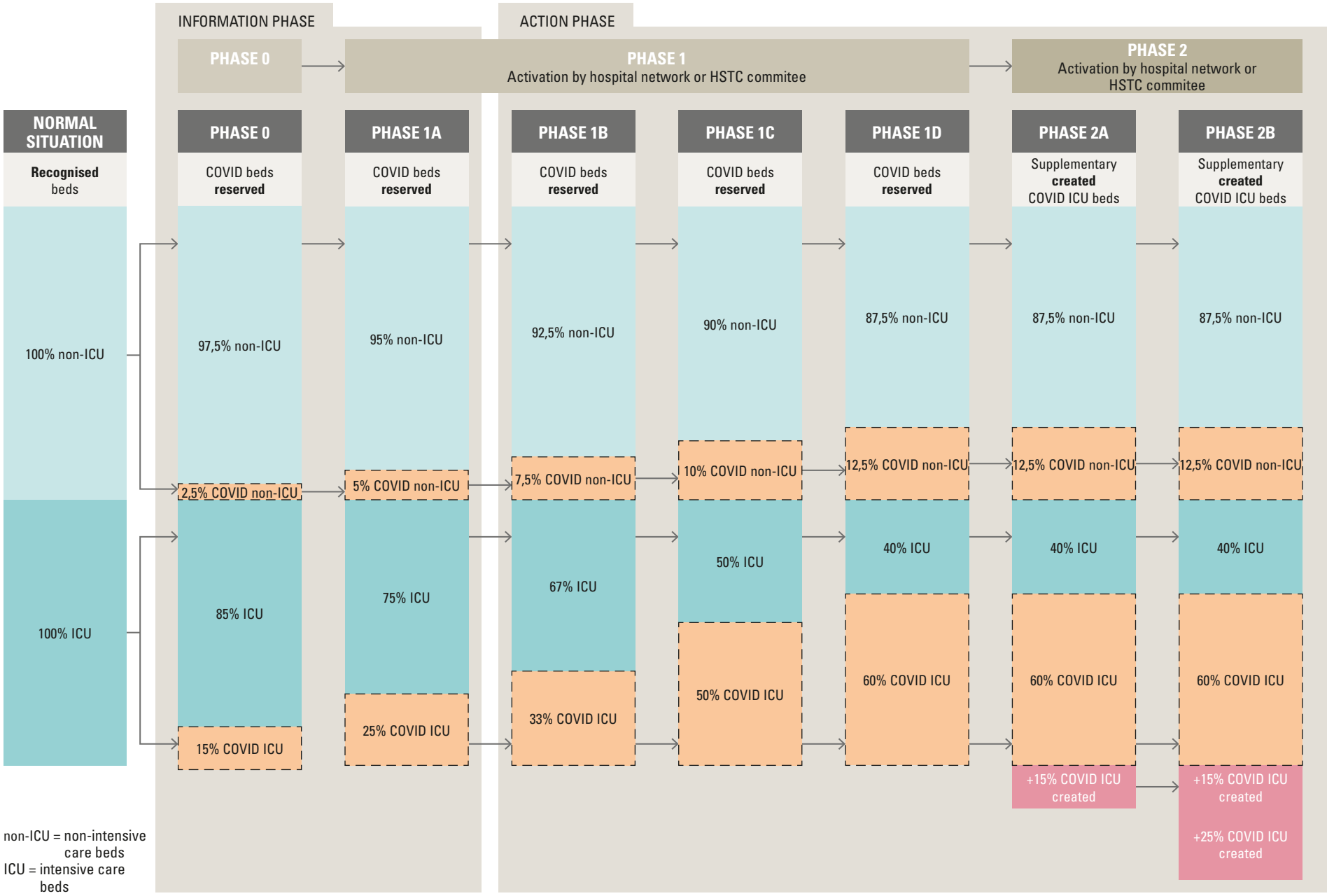
The plan was initially divided into **2 main phases**:

1. For the reception of COVID-19 patients in need of intensive care, the hospital only uses the intensive care beds that were already available in the period before the pandemic. In addition, a number of beds must be reserved for COVID-19 patients in the regular nursing units.

2. The hospital must create additional intensive care beds for the treatment of COVID-19 patients in need of intensive care and provide adequate staff for this purpose. In addition, beds must be reserved for COVID-19 patients (more than in the first phase) in the other departments for hospitalised patients.

The distribution plan was evaluated and revised several times during the pandemic to respond to the needs of the current situation each time.

DISTRIBUTION PLAN – VERSION 31/08/2022



4.2. Scaling back non-essential care

In mid-March 2020, it was communicated to hospitals via the HTSC Committee that all non-essential care had to be suspended. Particular attention had to be given to surgical interventions that had an impact on bed occupancy for the 'Intensive Care' function.

This decision was made for several reasons:

- To relieve the intensive care units;
- To free up health care providers to care specifically for COVID-19 patients;
- To optimise the use of medical equipment;
- To reduce the use of protective equipment which was scarce at the time.

Naturally, urgent and necessary care continued as before. In early May 2020, it was communicated that the restart of plannable, non-urgent care could be implemented in phases under strict conditions. Each hospital was required to maintain the capacity to treat patients from the first wave, and be ready to receive patients from the second wave. Furthermore, organisational measures were taken to avoid crowding, and ensure physical distancing between patients.

The following phases were formulated for the restart of these activities:

- Restart of consultations, home hospitalisation activities and the activities of mobile teams
- Restart of non-surgical day hospital activities (bv. geriatrics, psychiatry)
- Restart of surgical day hospital activities that do not use intensive care
- Restart of classic hospitalisations that do not use intensive care
- Restart of activities that use intensive care

In preparation for restarting care, the Federation of Belgian Professional Associations of Medical Specialists drew up a reference framework on the necessity and urgency of care that can serve as an orientation tool for doctors.

Find out more about this reference framework:

www.vbs-gbs.org

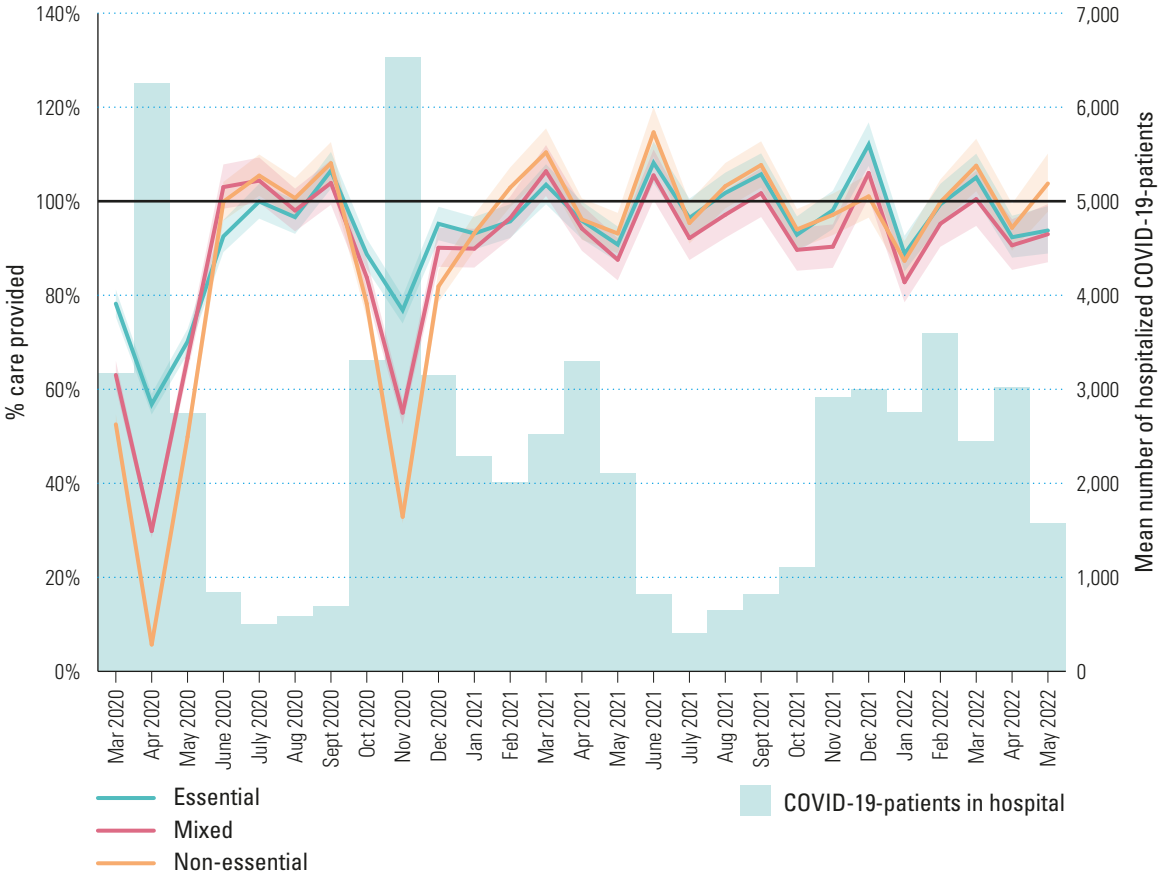
In the period leading up to the second wave (autumn 2020) these phases were reversed. Necessary and urgent care could take place as always. Furthermore, efforts were made to allow non-essential care to continue as much as possible. During the third wave (spring 2021), it was once again necessary to defer non-essential care. In this phase, hospital managers were asked to estimate which care could continue or not, depending on the specific situation. In the subsequent waves, hospitals were once more asked to show solidarity. They were also expected to provide the required bed capacity. If the hospital met these conditions, it could determine itself which activities had to be postponed.

As a result of the measures, in the first wave we observed a 94% reduction in surgical care classified as non-essential. We also observed that 57% of essential surgical care continued compared

to what would be expected. In the second wave, we saw a 66% reduction in non-essential surgical care and a 20% reduction in essential surgical care. The reduction in essential surgical care illustrates the impact of the COVID-19 pandemic as well as the reluctance of patients to request the necessary care.

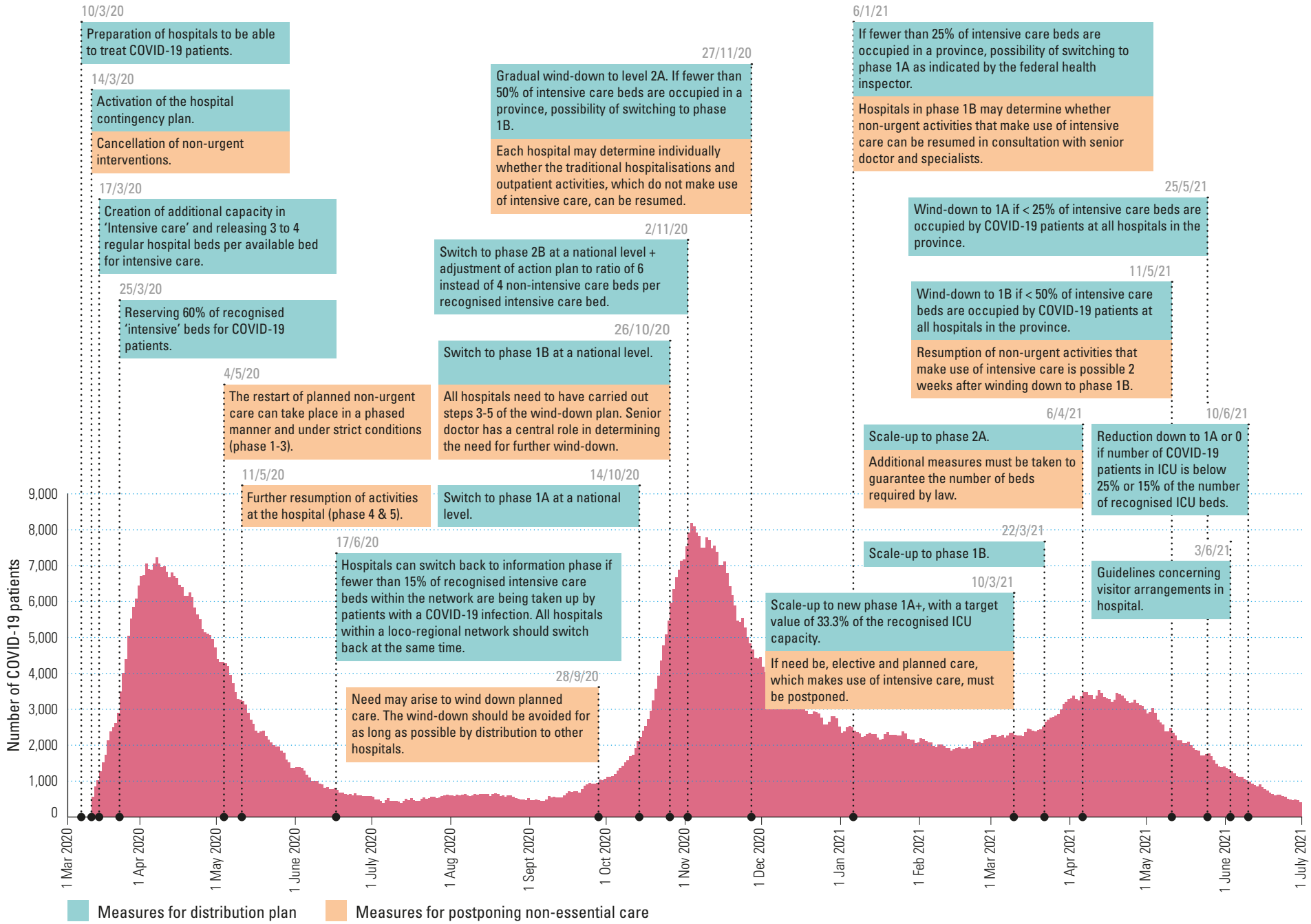
In 2021 and 2022, we observed a relatively limited fall in rates of care provided. The recovery activity in between is higher. During the third wave in April/May 2021, care provision dropped to a maximum of 87.5%. Here, for the first time, the drop in non-essential surgical care provision is comparable to or less pronounced than for essential and mixed care. During the fourth wave in November/December 2021, the drop was most pronounced for mixed surgical care; this dropped to 89.7% of the normal expected level. This equated to a reduction of 10.3%. In the period February to March, June and September 2021, there were some months with quite strong recovery activity, especially of non-essential surgical care, up to 10 to 14.5% above the estimates on the basis of the activities in pre-COVID-19 times (black 100% line). We see the greatest recovery activity mainly in non-essential surgical activities. This is not what we would expect based on medical prioritisation. In December 2021, however, we see the greatest recovery of 12% in essential surgical care. Between waves 5 and 6, we again observed that non-essential supplies show the greatest recovery.

EVOLUTION OVER TIME OF THE NUMBER OF PROVIDED NON-COVID HEALTHCARE SERVICES [4]

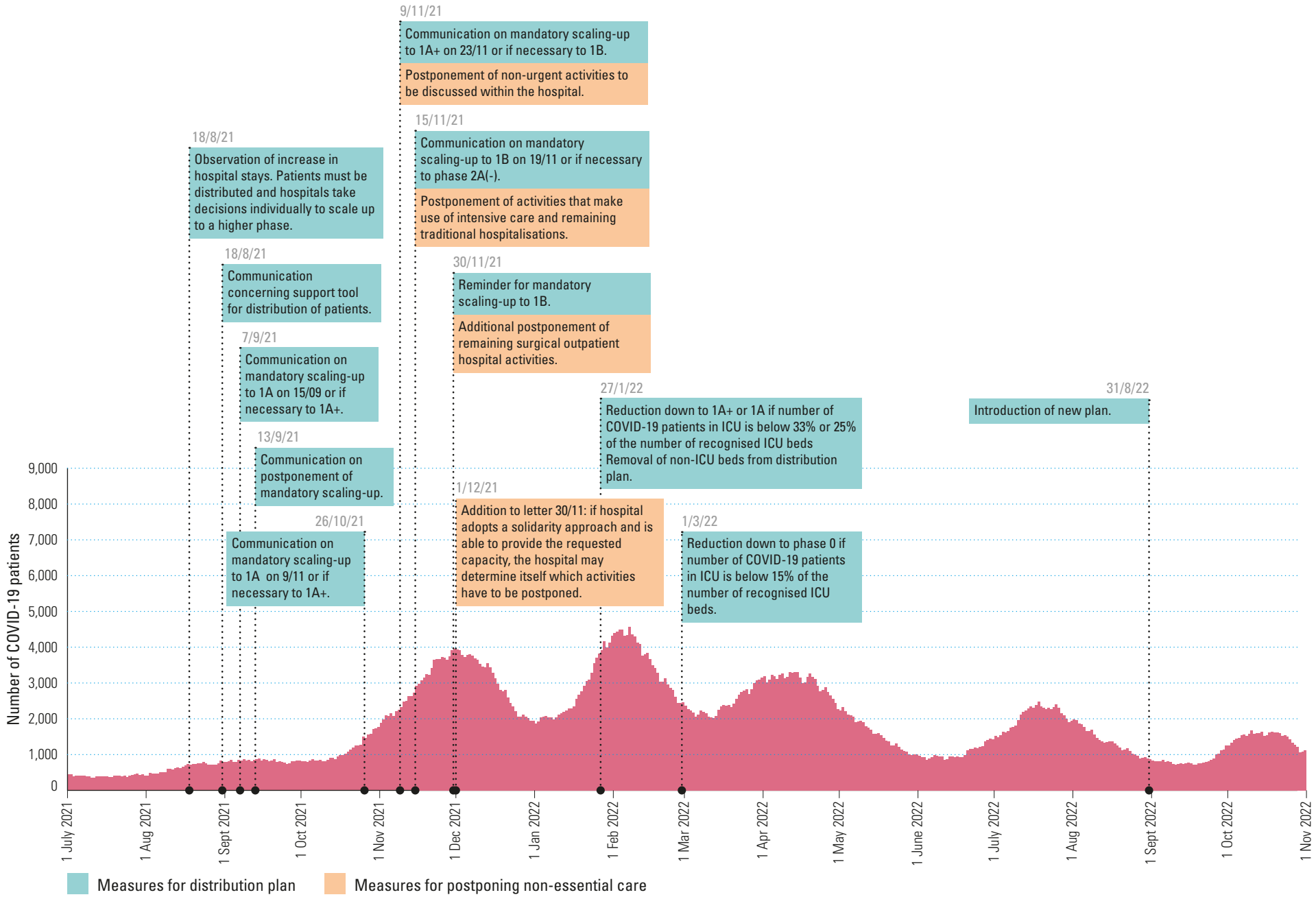


4 Source: https://www.riziv.fgov.be/fr/themes/qualite-soins/Pages/Covid5L2FR/Covid5L2FR.html. The black line shows an advanced estimate of the expected amount of care provided based on 2019 data. A classification was made according to surgical interventions regarded as non-essential, mixed and essential. The mixed category includes provided care which, depending on the context, could be either essential or non-essential.

OVERVIEW OF DISTRIBUTION PLAN MEASURES AND POSTPONEMENT OF NON-ESSENTIAL CARE AND CHANGE IN NUMBER OF COVID PATIENTS



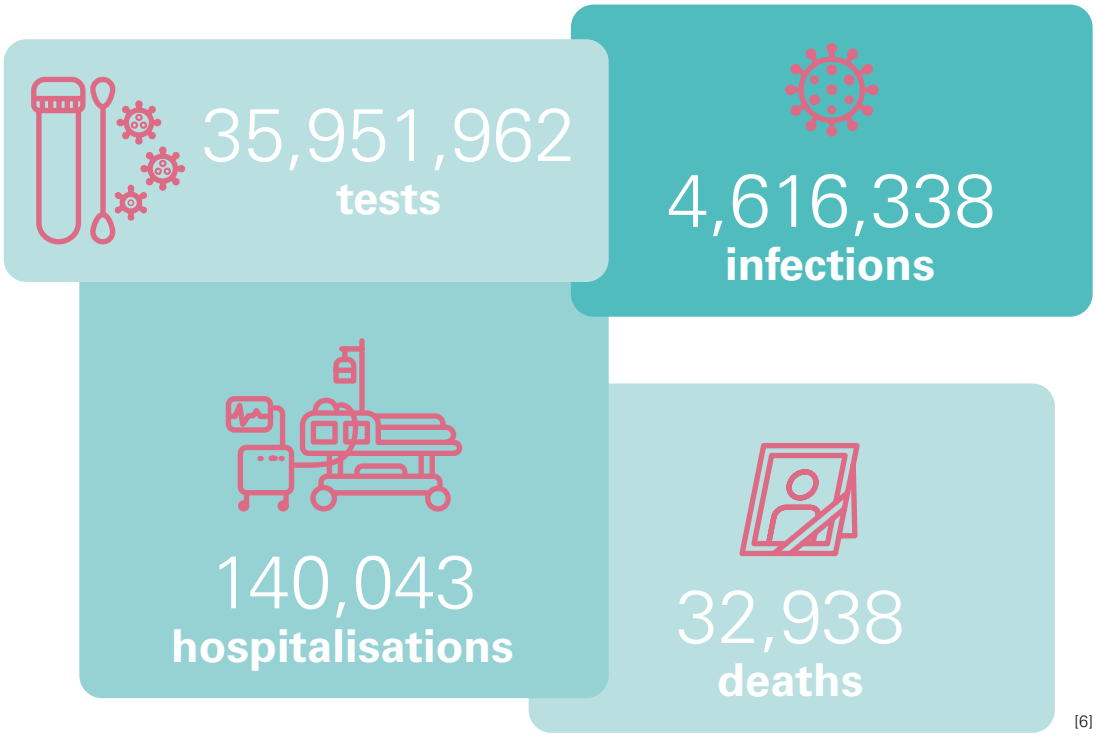
OVERVIEW OF DISTRIBUTION PLAN MEASURES AND POSTPONEMENT OF NON-ESSENTIAL CARE AND CHANGE IN NUMBER OF COVID PATIENTS



CARE ACTIVITY

This chapter presents some epidemiological data. The impact of the pandemic on hospital stays in general and psychiatric hospitals as well as on the operation of emergency care will be examined. The data will be looked at according to the different waves during the pandemic. We can distinguish eight waves to date[5]:

1. Epidemiological figures



[6]

1.1. Number of new infections and number of tests

In each COVID-19 wave, we notice a marked peak in the number of infections and in the positivity ratio[7].

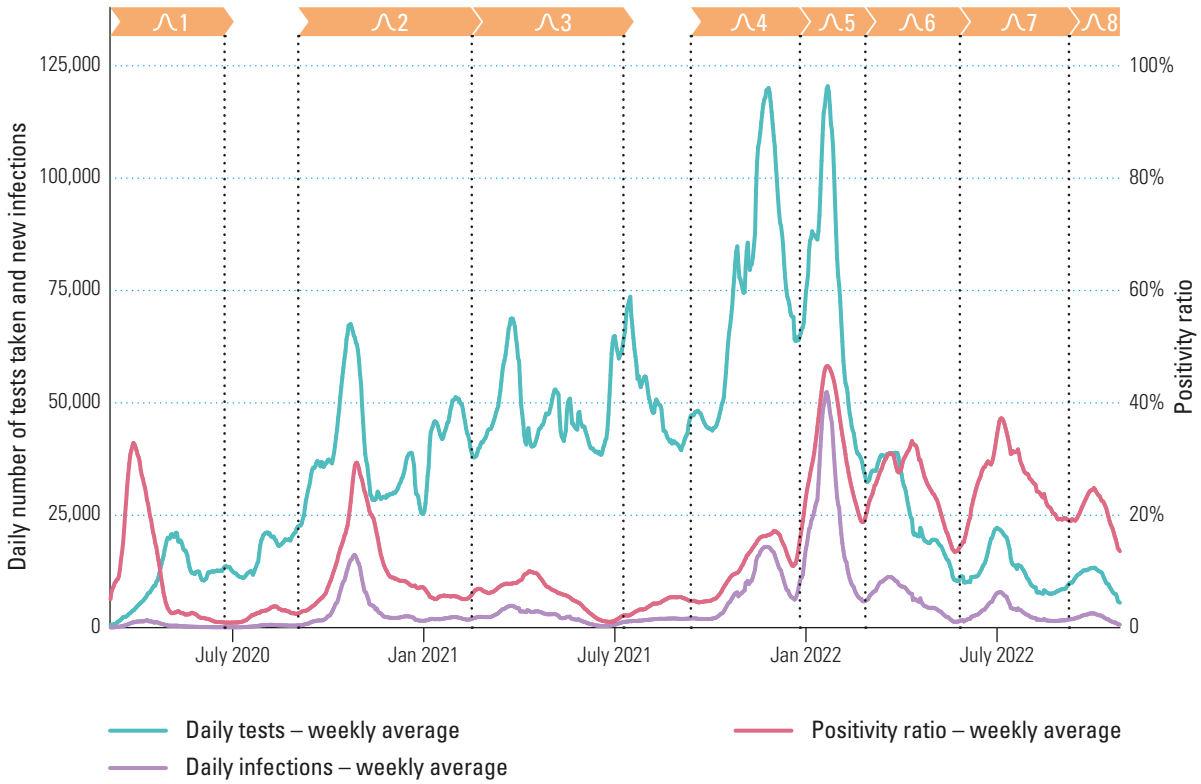
The highest number of infections were detected in the 5th wave with a peak of more than 50,000 infections per day on average.

5 Source: https://covid-19.sciensano.be/sites/default/files/Covid19/COVID-19_FAQ_ENG_final.pdf

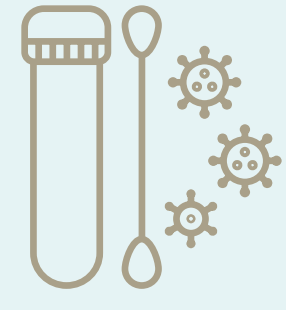
6 Source: Sciensano. This covers dates from the beginning of the pandemic to 31/10/2022

7 Source: Sciensano.

DAILY NUMBER OF NEW COVID-19 INFECTIONS AND TESTS TAKEN [8]



The number of people tested has shown an upward trend since the beginning of the pandemic, with an initial peak of over 65,000 tests per day on average during the second wave. This equates to a tripling of the number of tests per day compared to the first wave. Fewer tests were being taken at that time because testing capacity was limited. Consequently, fewer infections were detected. The testing strategy was altered several times throughout the pandemic and this affected the number of tests taken. For example, between 21/10/2020 and 22/11/2020, only persons with symptoms were tested and no tests were taken for persons with high-risk contact; from 2/2/2021, children over 6 years of age were also being tested. During the fourth and fifth waves, testing was at maximum capacity and an average of 120,000 tests were taken per day.



Highest number of tests taken in **4th** and **5th waves** with a peak of **120,000 tests** per day on average.

After the fifth wave, we observe a steep decline in the number of tests taken.

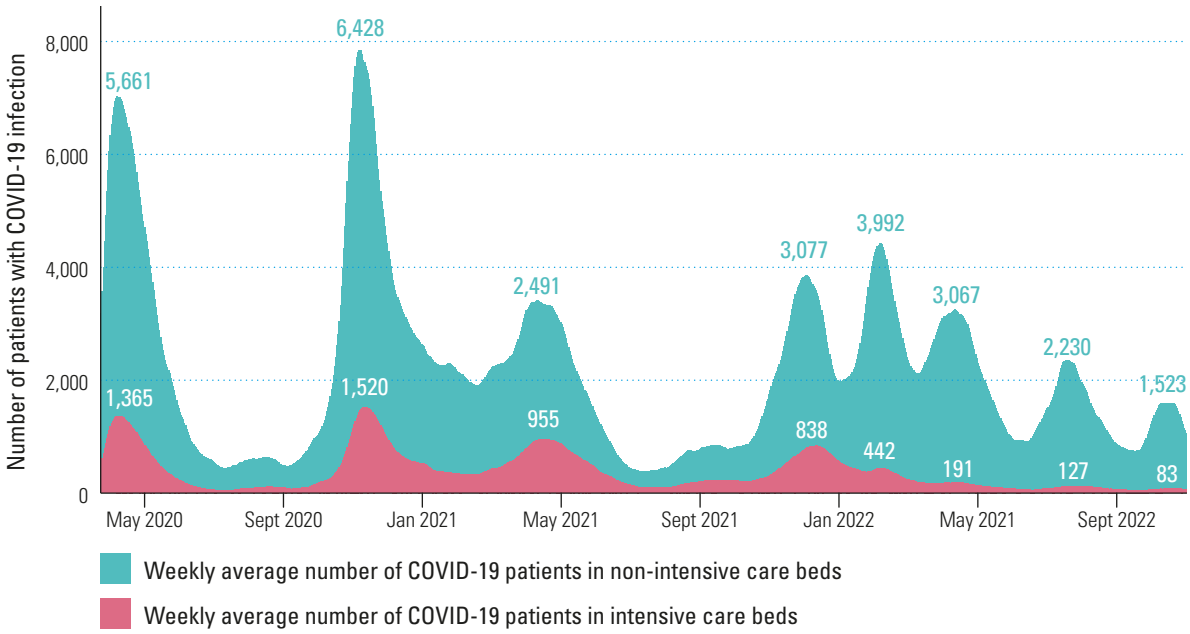
8 The positivity ratio represents the number of positive patients relative to the total number of people tested.

1.2. COVID-19 patients in general hospitals

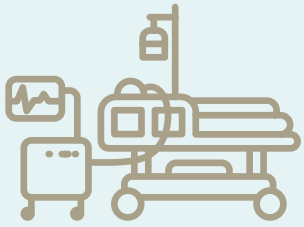
NUMBER OF COVID-19 PATIENTS IN GENERAL HOSPITALS

The number of hospital stays of COVID-19 patients was highest during the first and second wave. During the peaks of subsequent waves, half as many patients were admitted on average compared to the second wave in non-intensive care beds and one-third fewer patients in intensive care beds. Admissions to intensive care beds were significantly lower during the 5th wave. There are several factors that have had an impact on the number of hospitalisations: vaccination, more knowledge and experience in treatment among healthcare providers resulting in a shorter length of stay, a different mutation of the virus, better organisation of primary care, to name but a few.

NUMBER OF PATIENTS WITH COVID-19 INFECTION IN THE HOSPITAL [9]



BED OCCUPANCY RATES IN BEDS PROVIDED FOR COVID-19 PATIENTS IN GENERAL HOSPITALS

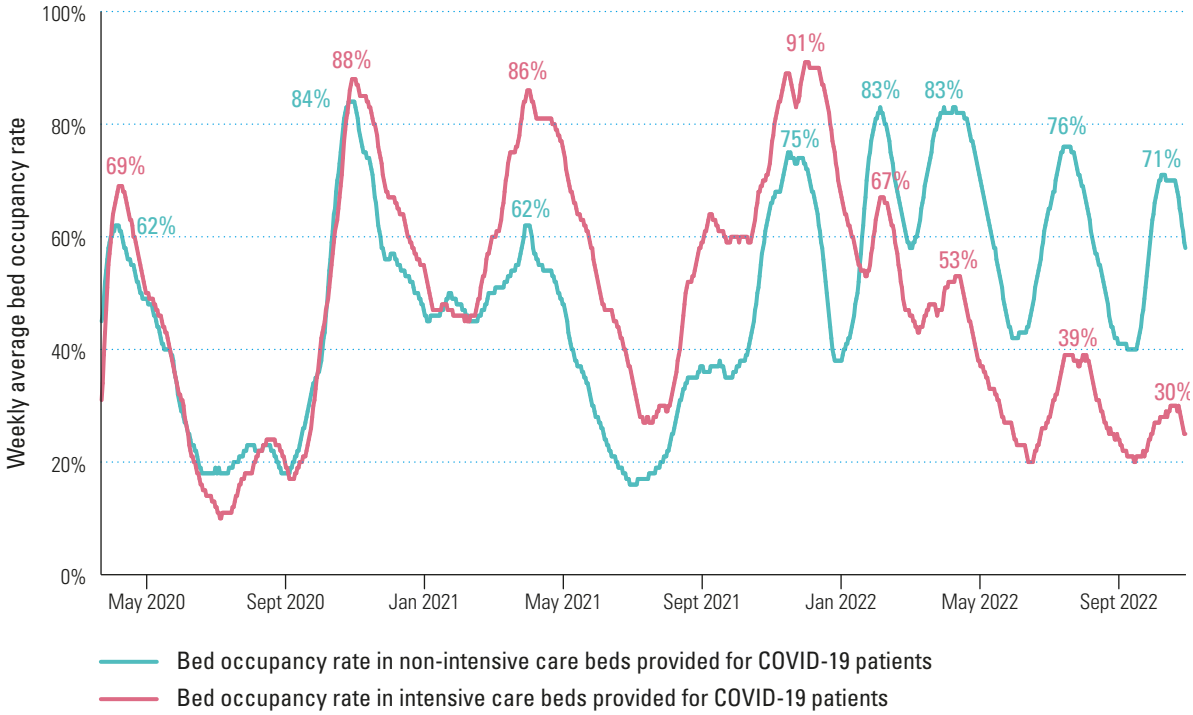


Bed occupancy rates were consistently **higher than** 85% in the **second, third and fourth wave** in intensive care beds reserved for COVID-19 patients.

9 Source: Sciensano

The graphic below shows the occupancy rate of beds provided for COVID-19 patients for intensive and non-intensive care. During the peak of the first and second wave, the occupancy rates for both types of beds are similar, around 65% and 85% respectively. This changes in the third and fourth wave, where occupancy rates for intensive care beds are significantly higher, between 86% and 91%, than those for non-intensive care beds. In the fifth wave, we observe the opposite situation where the occupancy rate for non-intensive care beds with a peak of 83% is higher than that for intensive care beds (peak of 67%). This trend continues in the subsequent waves, with the peak in October 2022 reaching 71% for non-intensive care beds and 30% for intensive care beds.

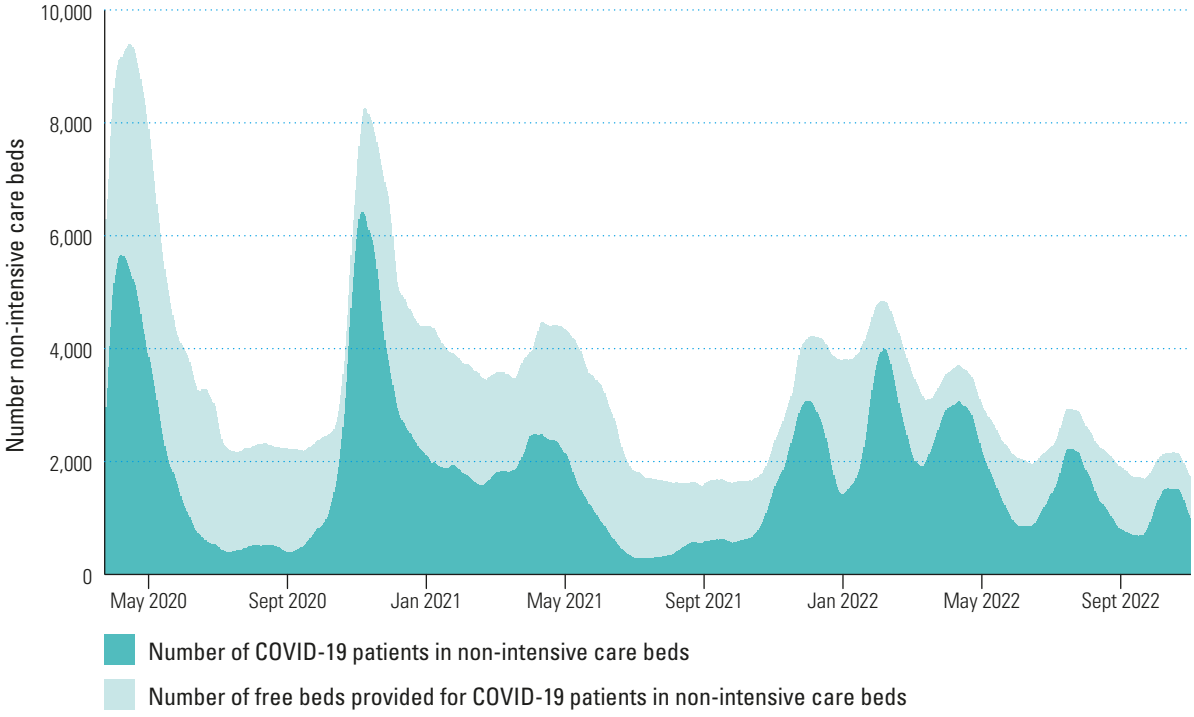
BED OCCUPATION RATE
EXPRESSED AS A PERCENTAGE OF THE TOTAL NUMBER OF BEDS PROVIDED [10]



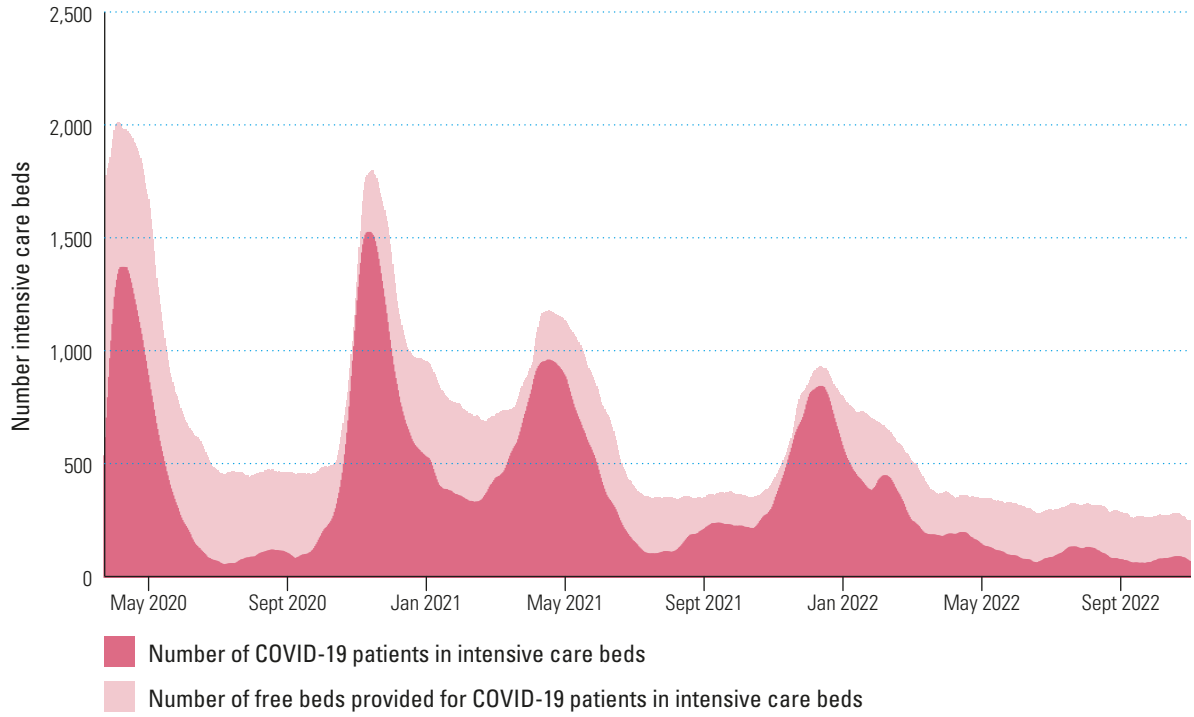
The graphics below show the number of available intensive care and non-intensive care beds for COVID-19 patients as well as the number of COVID-19 patients who were admitted to the hospital. Here, we can clearly see that significantly more beds were reserved for COVID-19 patients during the first two waves than in the subsequent waves. To better understand these figures, it is important to take into account that a distribution plan was drawn up by the federal government that defines a system of redeploying beds (see chapter Organisation). This model informed hospitals of the number of beds they needed to make available for COVID-19 patients given the situation at the time. During the first wave, this model was not yet available. All non-essential care was shut down and the remaining beds were reserved for COVID-19 patients. This explains the lower occupancy rate during this period. This concerns the early period of the pandemic during which there was little knowledge and experience regarding the COVID-19 virus. At this time, the virus hit our country and surrounding countries hard. During the subsequent waves, an attempt was made to strike a balance between performing regular care and being able to accommodate the influx of COVID-19 patients. In addition, during the later waves, fewer beds were available because of staff absences due to constant, high workloads and infections, among other things.

10 Source: Sciensano and ICMS

NUMBER OF BEDS PROVIDED FOR COVID-19 PATIENTS
IN NON-INTENSIVE CARE BEDS



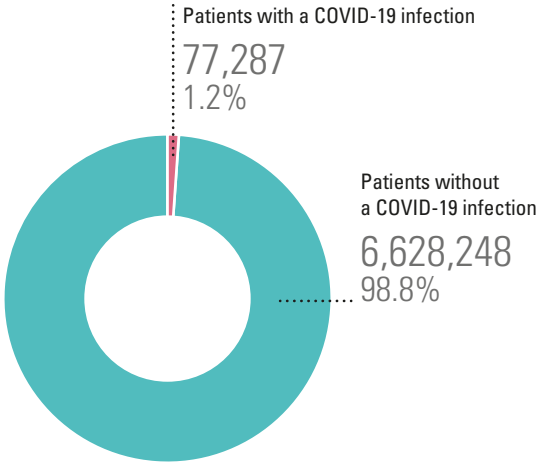
NUMBER OF BEDS PROVIDED FOR COVID-19 PATIENTS
IN INTENSIVE CARE BEDS



PROFILE OF COVID-19 PATIENTS[11]

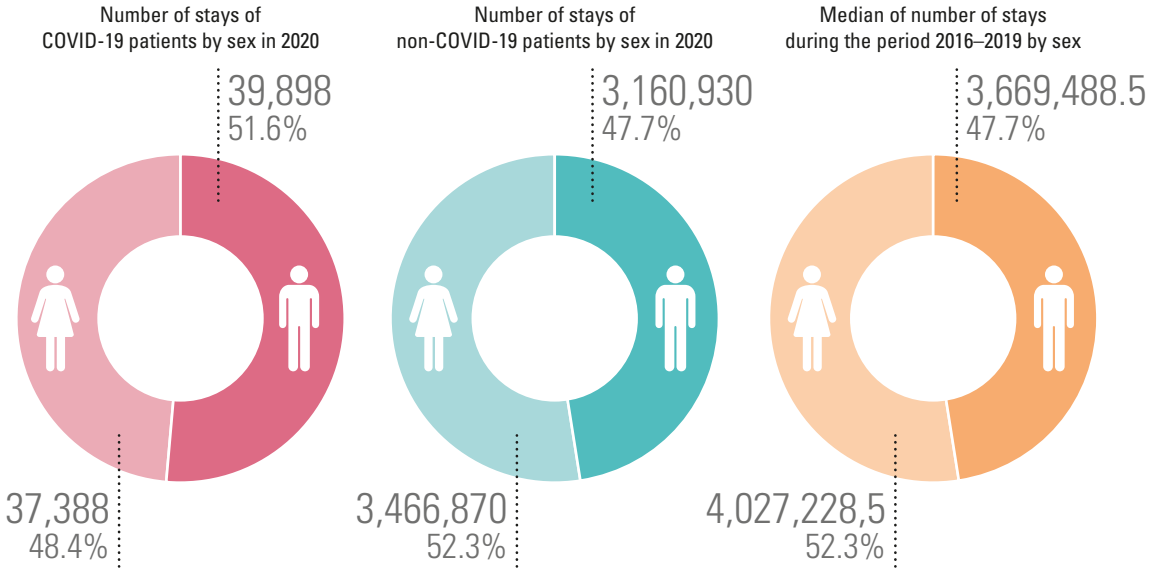
In 2020, 1.2% of all stays (i.e. classic hospitalisation, day hospitalisation and outpatient contacts with the emergency department) were COVID-19 patients.

NUMBER OF STAYS OF PATIENTS WITH AND WITHOUT A COVID-19 INFECTION IN 2020



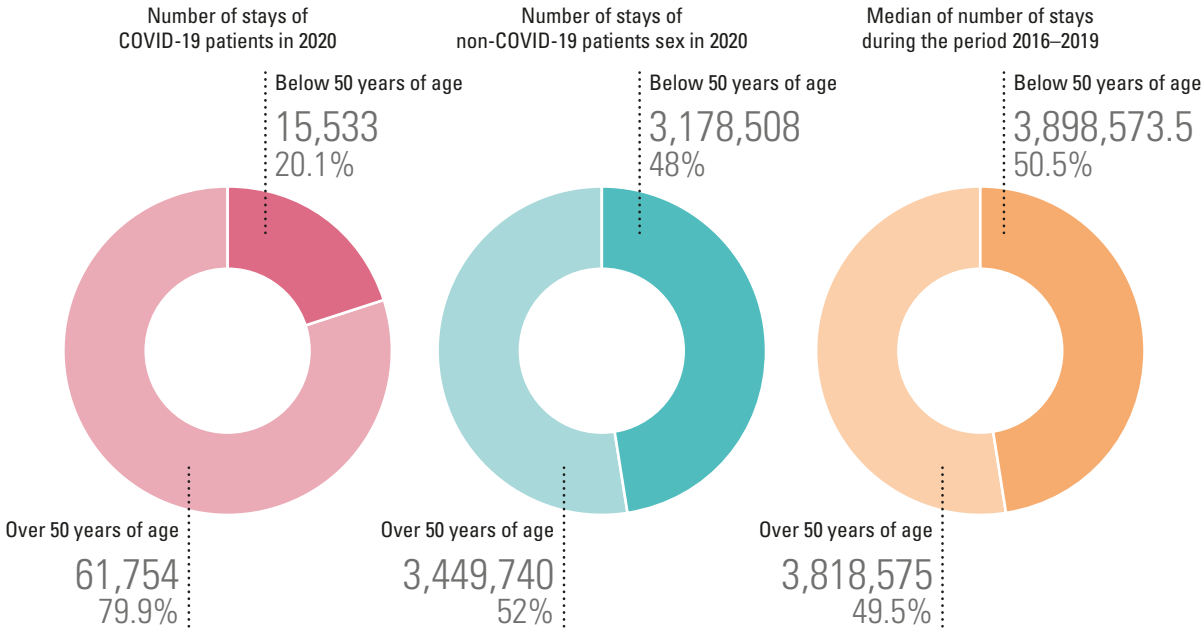
Gender and age

When comparing characteristics of stays of COVID-19 patients with stays of non-COVID-19 patients in 2020 and stays in the period from 2016 to 2019, one finds that the number of hospitalised men and women is similar.



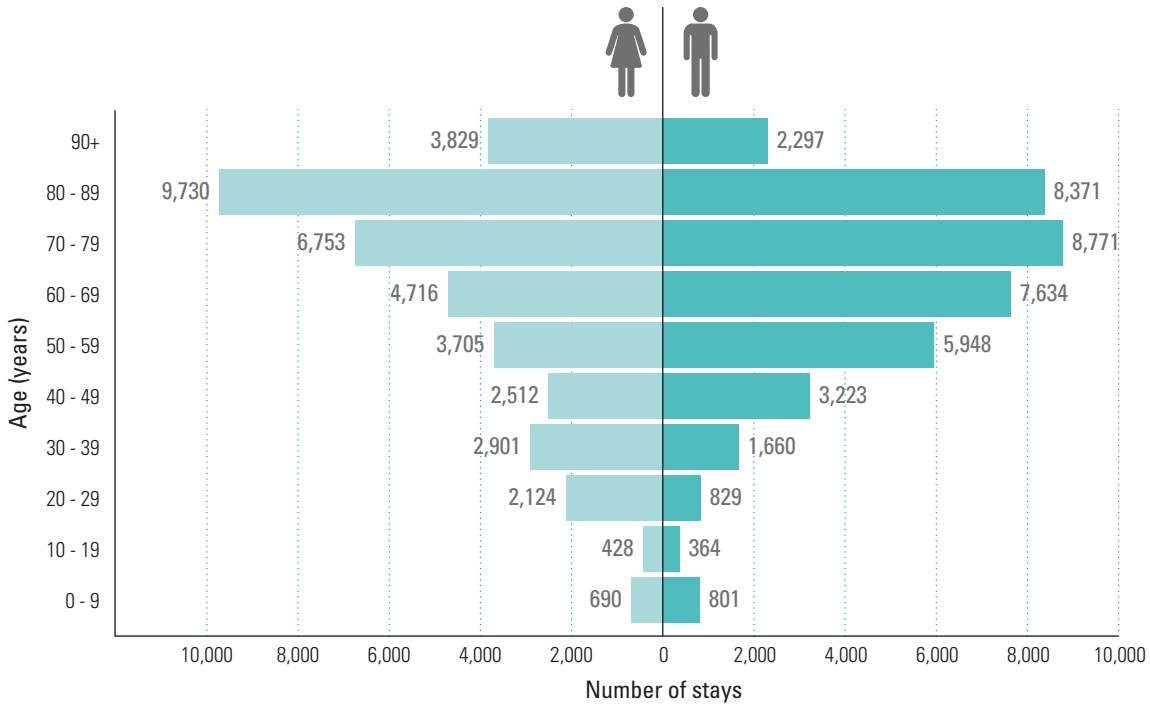
Furthermore, 79.9% of patients hospitalised with COVID-19 infection in 2020 was aged 50 or over. This is in sharp contrast with the age of patients without COVID-19 infection in 2020 (52.0%) and with the age of patients in the period from 2016 to 2019 (49.5%).

11 Source: Minimal hospital data (MHD), Data and Policy Information Service, FPS HSFCE. At the time of publication, our services only have data for 2020 to construct a profile of COVID-19 patients. All patients with confirmed or suspected COVID-19 infection were included in the figures, regardless of the reason for admission. It is also possible that patients who were transferred to a different hospital during their hospital stay were counted twice.



In the age groups from 40 to 79 years, in 2020 consistently more men with COVID-19 infection than women were hospitalised. We also find that more women than men were hospitalised in the age group from 20 to 39 years as well as in the age group from 80 years old. The higher number of women in the first group may in part be explained by the fact that this is the age at which women usually become pregnant. In that case, mild COVID-19 infection may have been detected when the woman was admitted to give birth[12]. It is also possible that these women were admitted out of precaution in the event of COVID-19 infection during pregnancy. In the second age group, from 80 years old, the higher number of hospitalised women can be explained by the fact that the female population is more numerous in this age group.

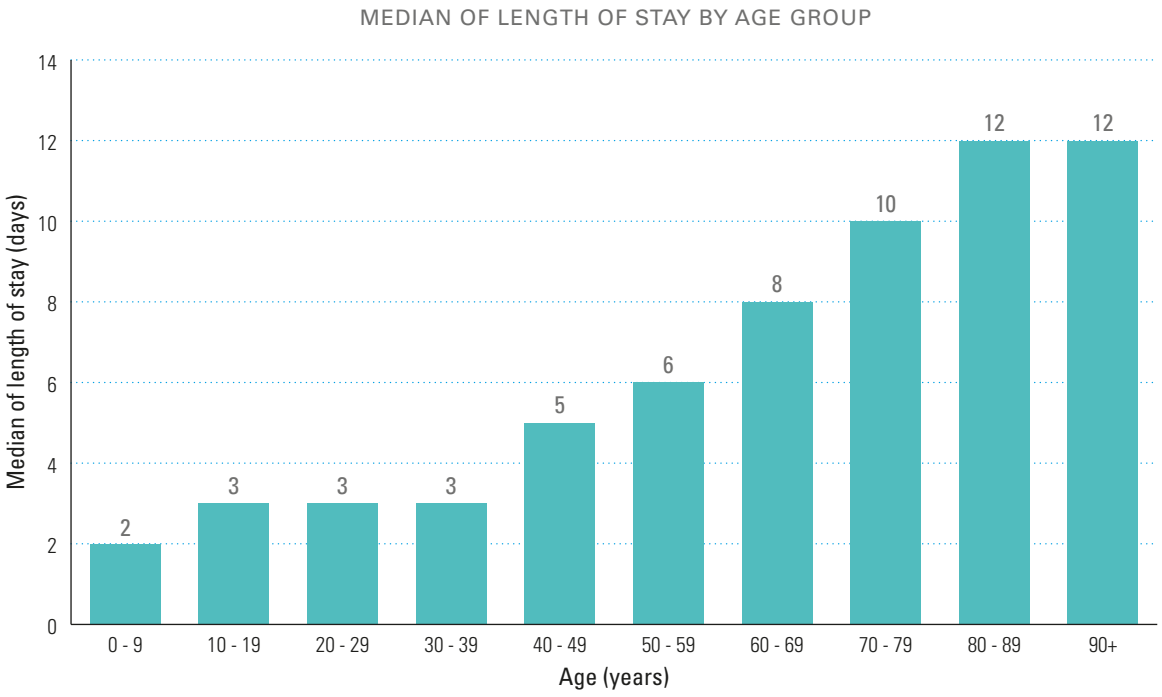
NUMBER OF STAYS OF COVID-19 PATIENTS BY SEX AND AGE GROUP IN 2020



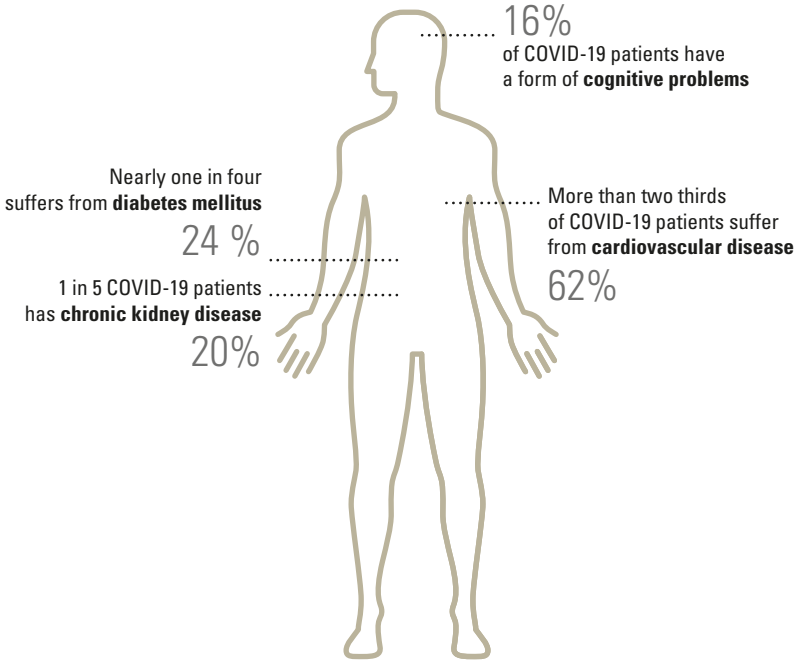
12 It is impossible to determine whether the person was hospitalised due to COVID-19 infection or due to another condition, where COVID-19 infection was only detected by the mandatory test on admission.

Length of stay

The median[13] length of stay increases with the patient's age, from 2 days for 0 to 9-year-olds to 12 days for people aged 80 and over.



Comorbidity



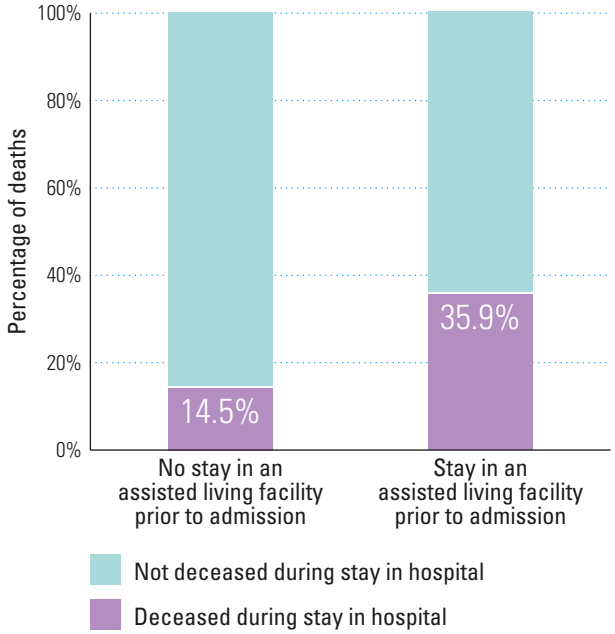
13 We have opted for showing the median value because this statistic is less affected by extreme values than the average. The median is the value situated exactly in the middle of a data set when you place the values from low to high. It is a centre value that separates the lowest 50% of the values from the highest 50%.

Mortality in general hospitals

17% of all patients diagnosed with COVID-19 infection died in a hospital in 2020.

The percentage of deaths is higher for patients from assisted living facilities who were admitted to a hospital (35.9% compared to 14.5%).

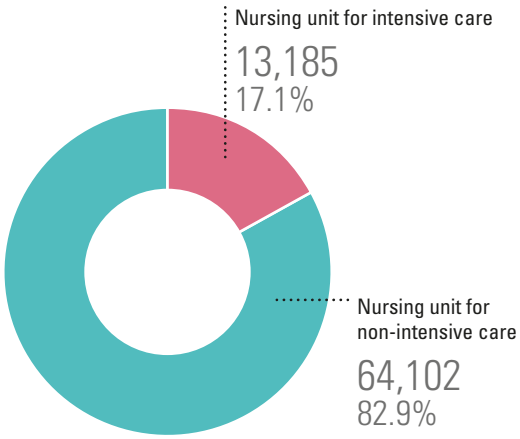
PERCENTAGE OF DEATHS IN THE HOSPITAL ACCORDING TO WHETHER THE PATIENT STAYED IN AN ASSISTED LIVING FACILITY PRIOR TO THE HOSPITAL STAY



PROFILE OF COVID-19 PATIENTS IN INTENSIVE CARE

In 2020, 17.1% of patients with COVID-19 infection that were hospitalised were admitted in intensive care units.

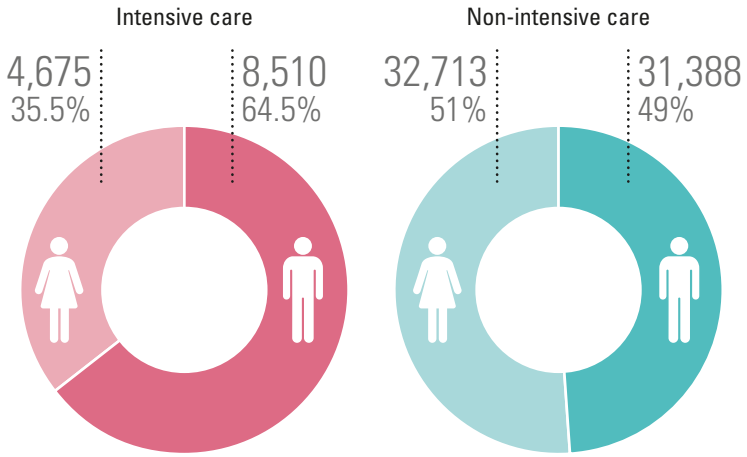
NUMBER OF STAYS OF COVID-19 PATIENTS IN (NON-)INTENSIVE CARE



Gender and age

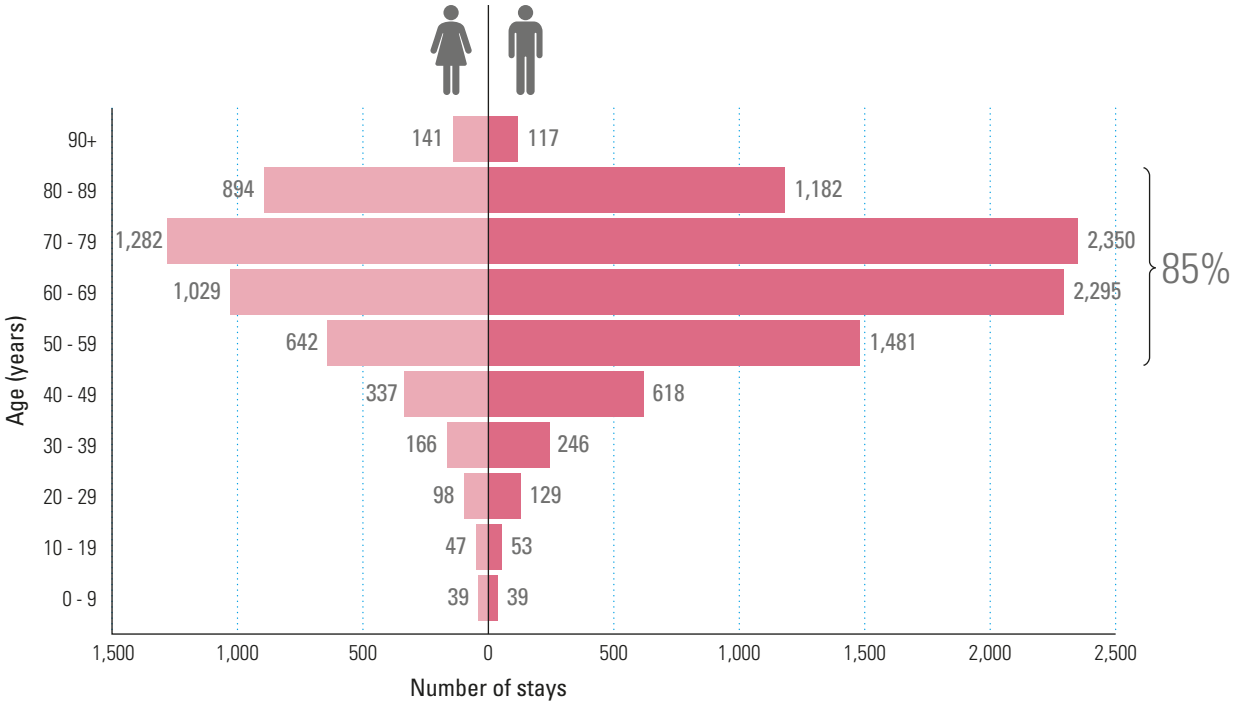
64.5% of all patients with COVID-19 infection who were admitted in intensive care units were male.

PERCENTAGE OF (NON-)INTENSIVE CARE STAYS
BY SEX AMONG COVID-19 PATIENTS



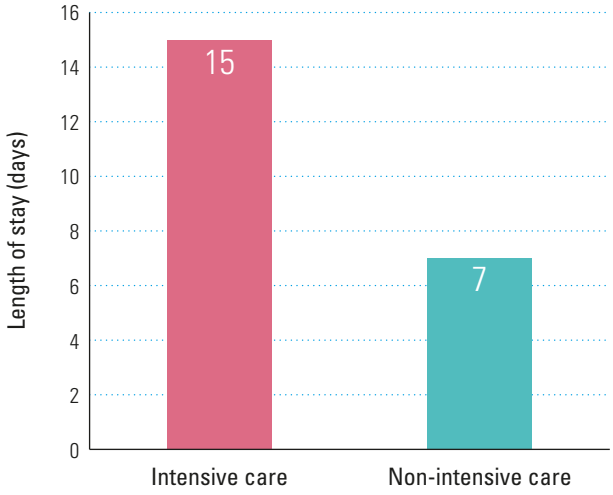
85% of all stays of patients with COVID-19 infection in an intensive care unit pertained to patients between the ages of 50 and 89 in 2020.

NUMBER OF INTENSIVE CARE STAYS
BY AGE GROUP AMONG COVID-19 PATIENTS



Length of stay

MEDIAN OF LENGTH OF STAY
IN (NON-)INTENSIVE CARE
AMONG COVID-19 PATIENTS

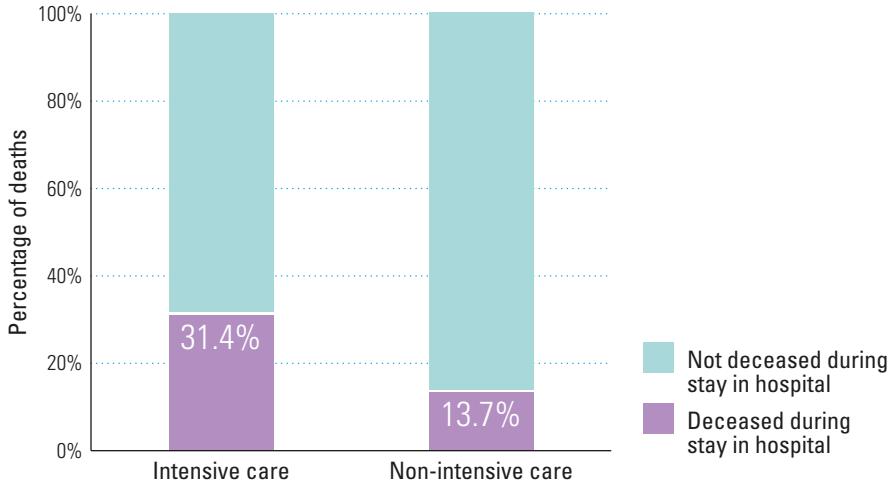


The median of the total length of stay in hospital in 2020 was 15 days if the COVID-19 patient was admitted in an intensive care unit. For patients who were hospitalised in a regular nursing unit, the median of the length of stay was one week.

Mortality in general hospitals

One third of COVID-19 patients admitted in an intensive care unit died in hospital in 2020. COVID-19 patients who did not end up in an intensive care unit died in 13.7% of cases.

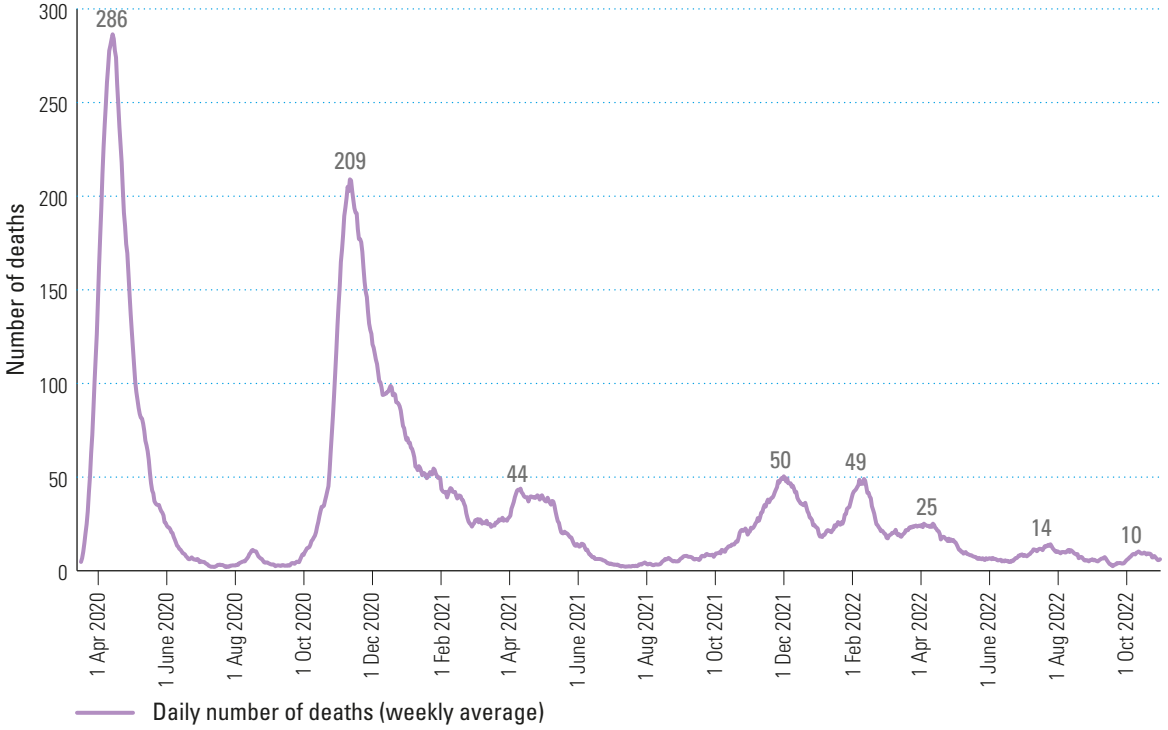
PERCENTAGE OF DEATHS AMONG COVID-19 PATIENTS IN (NON-)INTENSIVE CARE



1.3. Total number of deaths resulting from COVID-19

The first and second wave saw an average of over 200 deaths per day occurred within and outside of hospitals. This rate dropped significantly during subsequent waves, where the average number of daily deaths hovered around 50 deaths in the fourth and fifth wave. Since May 2022, the average has fluctuated between 4 to 14 deaths per day.

DAILY NUMBER OF DEATHS RESULTING FROM A COVID-19 INFECTION [14]



14 Source: Sciensano

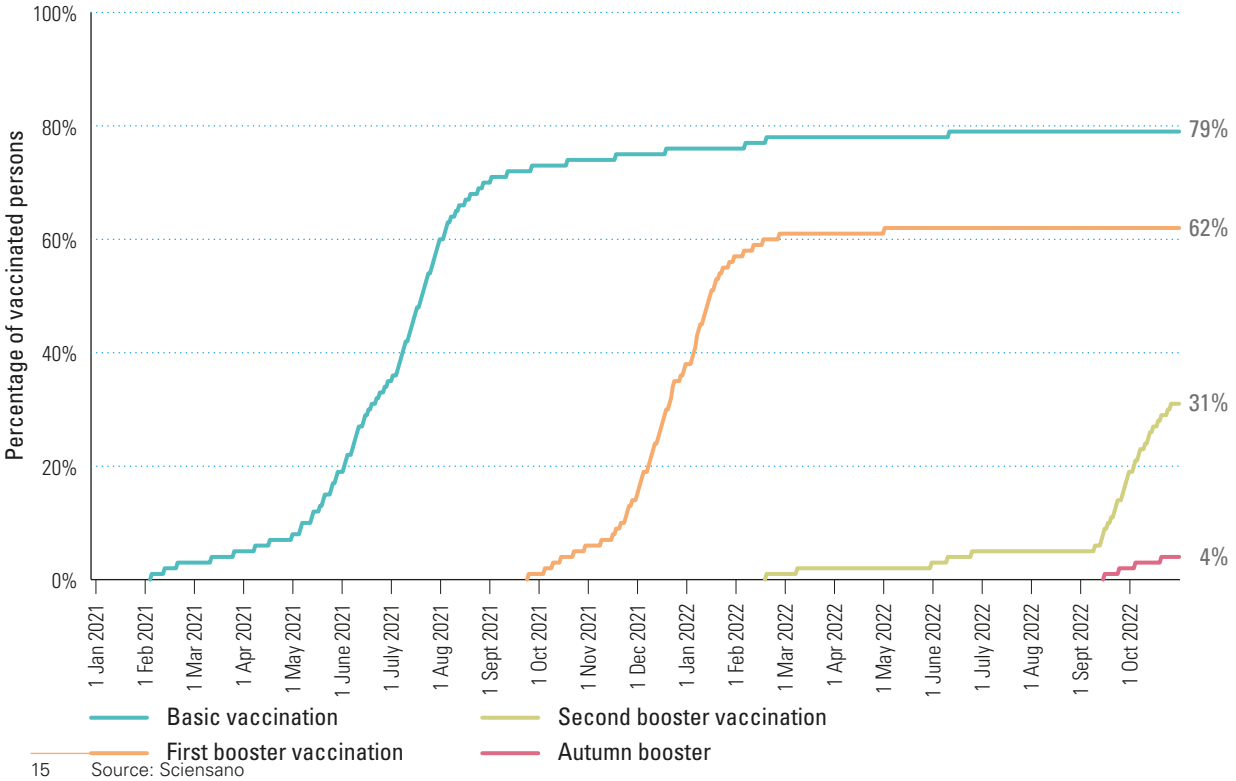
1.4. Vaccination

The vaccination campaign was divided into different phases:

Early January 2021	Basic vaccination of residents of assisted living facilities, healthcare staff, persons over 65 years of age and high-risk patients, respectively.
June 2021	Basic vaccination of the wider population in first instance for persons aged 18 years and older and thereafter for young people between 12 and 17 years of age
September 2021	Booster campaign for immunocompromised persons, residents of assisted living facilities, persons aged 65 and older, and healthcare personnel.
December 2021	Booster vaccination of the wider population in first instance for persons aged 18 years and older and thereafter for young people between 12 and 17 years of age, plus option for vaccination of 5 to 11 year-olds.
Spring 2022	Second booster for immunocompromised persons, residents of assisted living facilities, persons aged 80 and older.
Autumn 2022	Autumn booster to which all people over 50, caregivers and immuno-compromised persons will be actively invited. Other individuals may also obtain a booster.

The graphic below gathers data from all persons who received a vaccine. By 31 October 2022, 79% of the total Belgian population had been given a basic vaccination. In addition, 62% had also been given a first booster vaccine, 31% a second booster vaccine and 4% an autumn booster.

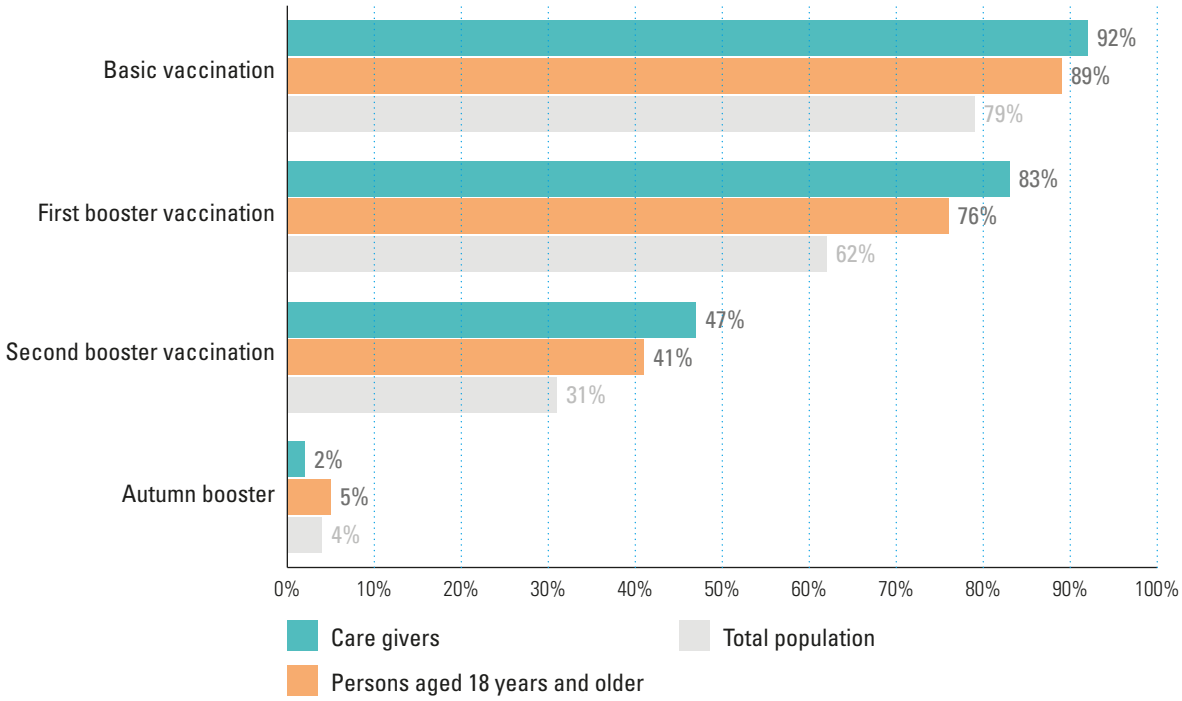
PERCENTAGE OF VACCINATED PERSONS BY TYPE OF VACCINATION [15]



15 Source: Sciensano

Below, we compare the percentage of vaccinated persons aged 18 years and older and the percentage of vaccinated healthcare workers by 31/10/2022. Here, we observe that the percentage of persons who received a complete baseline vaccination is similar. However, we notice a greater variation in the percentage of individuals who obtained a first and second booster. We see that a larger percentage of caregivers obtained a booster. Since the autumn booster, however, we see the first time that the general population was more likely to obtain the booster than caregivers, but this figure may still rise.

VACCINATION RATE AMONG CARE GIVERS
AND PERSONS AGED 18 AND OVER (31/10/2022)

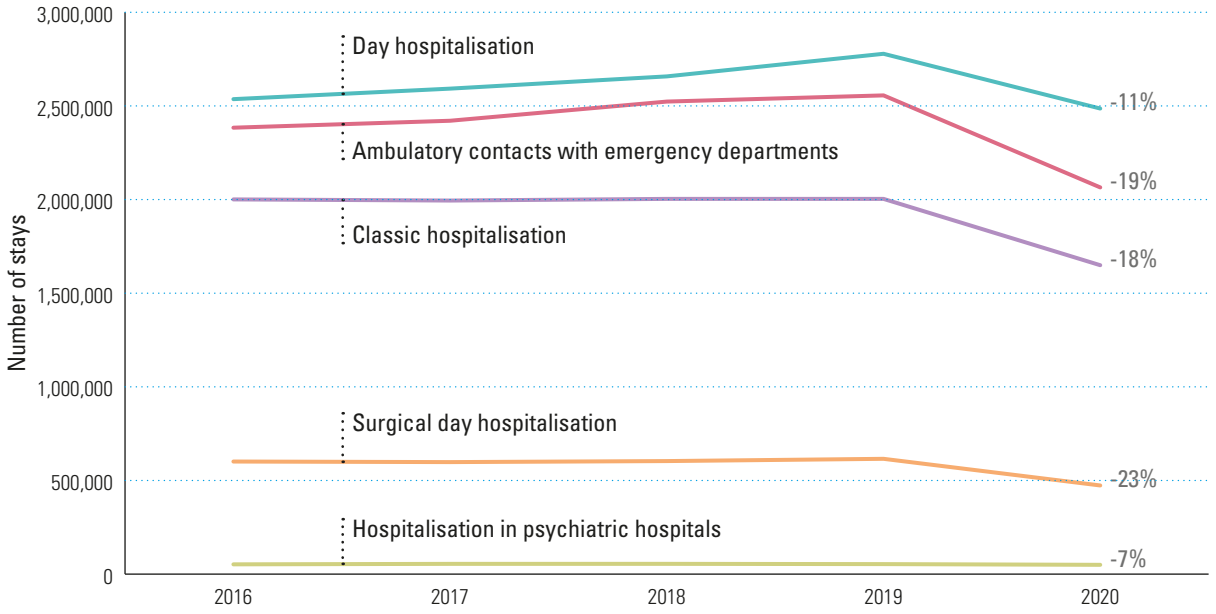


2. Impact of the pandemic on hospital stays in general and psychiatric hospitals in 2020

The postponement of non-essential care and the treatment of COVID-19 patients had a considerable impact on hospital activity in 2020. We find that the number of stays decreased by 16% in general hospitals and by 7% in psychiatric hospitals[16]. The greatest decrease, by 23%, can be observed in the number of surgical day hospitalisations. The strong reduction in the number of outpatient contacts with the emergency department could be an indirect consequence of the measures taken in 2020. Indeed, especially during the first wave, social contacts were greatly limited, teleworking became the norm, and work in some sectors came to a complete halt. As a result, fewer accidents occurred, which led to a lower number of contacts with the emergency department.

16 Source: MHD and MPD, Data and Policy Information Service, FPS HSFCE. At the time of publication, our services only have data for 2020 for all stays (both COVID-19-related and non-COVID-19-related) in general and psychiatric hospitals.

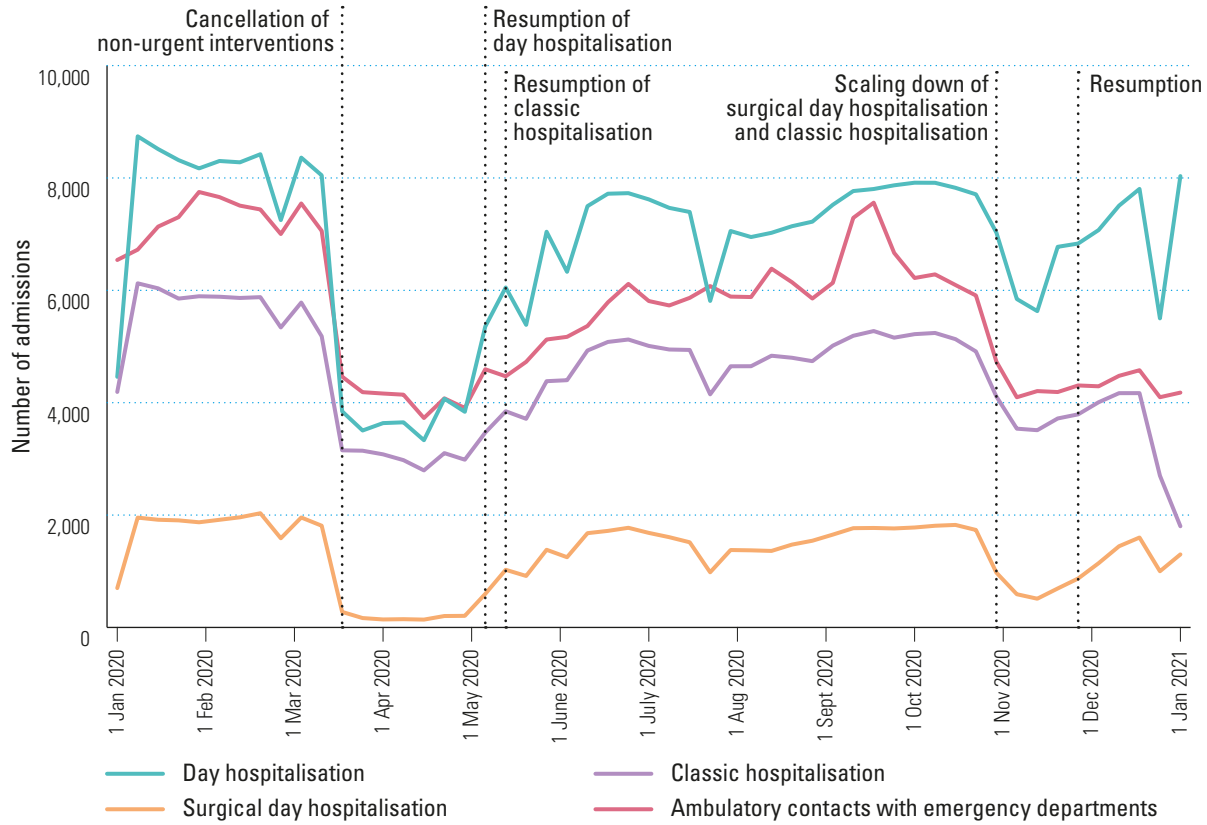
EVOLUTION IN THE NUMBER OF STAYS PER TYPE OF STAY



Both in March and in November 2020, we see a clear effect of the measures taken regarding the postponement of non-essential care. There is a considerable drop in the number of stays for all types of hospitalisations. At the restart of day hospitalisation and classic hospitalisation in May 2020, we observe that the number of stays remains below the level of the number of stays in January and February 2020.

In November 2020 – when the second wave of COVID-19 hits – we once again observe a considerable reduction in activity as a result of the measures taken. Although at that time this was not part of the measures adopted, we also see a reduction in non-surgical day hospitalisations.

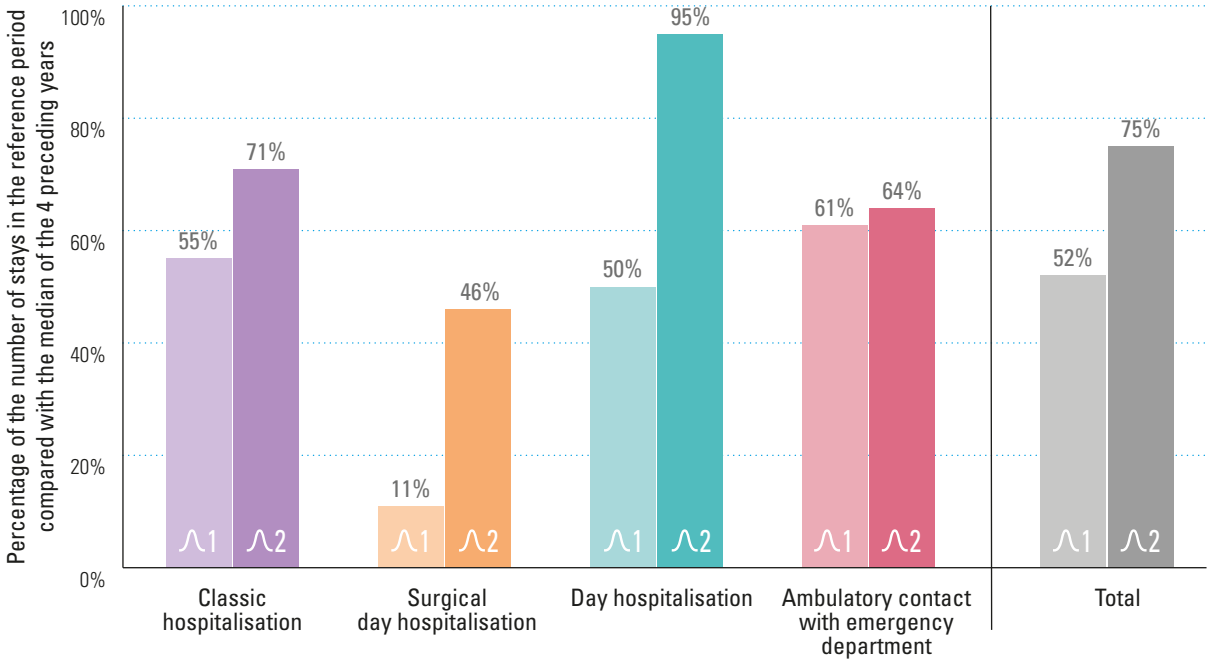
EVOLUTION IN THE WEEKLY NUMBER OF ADMISSIONS PER TYPE OF STAY



During the period from 14/3/2020 to 4/5/2020[17] we saw that the total number of hospital stays more or less halved in 2020 compared to the median of the number of stays in the years 2016 to 2019. The greatest reduction could be observed in surgical day hospitalisations, where only 11% of expected stays took place. Classic hospitalisations, non-surgical day hospitalisations and ambulatory contacts through the emergency department saw a drop to 55%, 50% and 61%, respectively, compared to the activity in the previous four years.

In the period from 26/10/2020 to 27/11/2020, 75% of expected stays took place, compared to the activity in the period from 2016 to 2019. Once again, we observe the greatest reduction in surgical day hospitalisations, where 46% of expected stays took place, followed by ambulatory contacts with the emergency department (64%), classic hospitalisation (71%), and non-surgical day hospitalisation (95%).

PERCENTAGE OF THE NUMBER OF STAYS IN THE REFERENCE PERIOD COMPARED WITH THE MEDIAN OF THE 4 PRECEDING YEARS BY HOSPITALISATION TYPE [18]



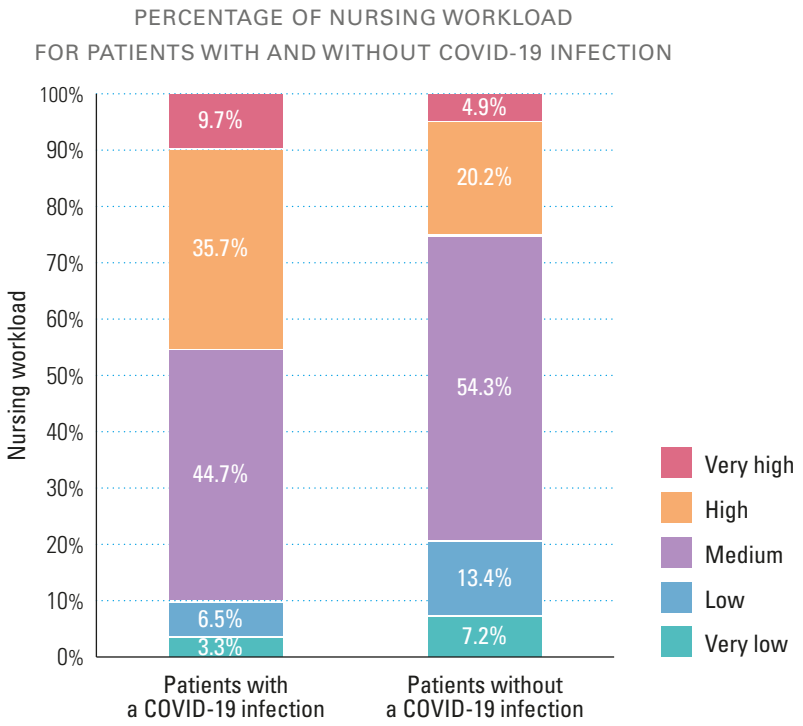
In the two periods where non-essential care was postponed, one third of hospitalisations of non-COVID-19-patients was a contact for chemo or immune therapy (28%), 11% a stay relating to a form of chronic pain, and 6% of stays were for giving birth.

17 The reference periods chosen are the periods in which the HTSC Committee asked to postpone non-essential care. Hence, these periods do not comprise the entire COVID-19 wave. Due to the nature of the registration, these figures cannot be shown for the evolution of the number of stays in psychiatric hospitals.

18 For stays in psychiatric hospitals, due to the manner of registration, no comparison can be made based on the number of stays in the chosen reference periods. For this reason, these stays are not included in this graph.

2.1. Impact of the pandemic on the nursing workload

In the graph below, an overview is given of the general nursing workload for patients with and without a COVID-19 diagnosis. The general nursing workload gives an idea of the care needs of the patient. These are determined based on how many nursing care services were performed, how much time was necessary to provide the care services, or the degree of nursing competency required for the care services.



For 46% of COVID-19 patients, the nursing workload is high to very high, which means that the nursing workload amounts to more than 150% of the nursing workload for the average patient[19]. In addition, for 10% of patients, the nursing workload is even more than 3 times as high as for the average patient. By way of comparison, we find that only 25% of patients without COVID-19 infection are classified into the categories high to very high.

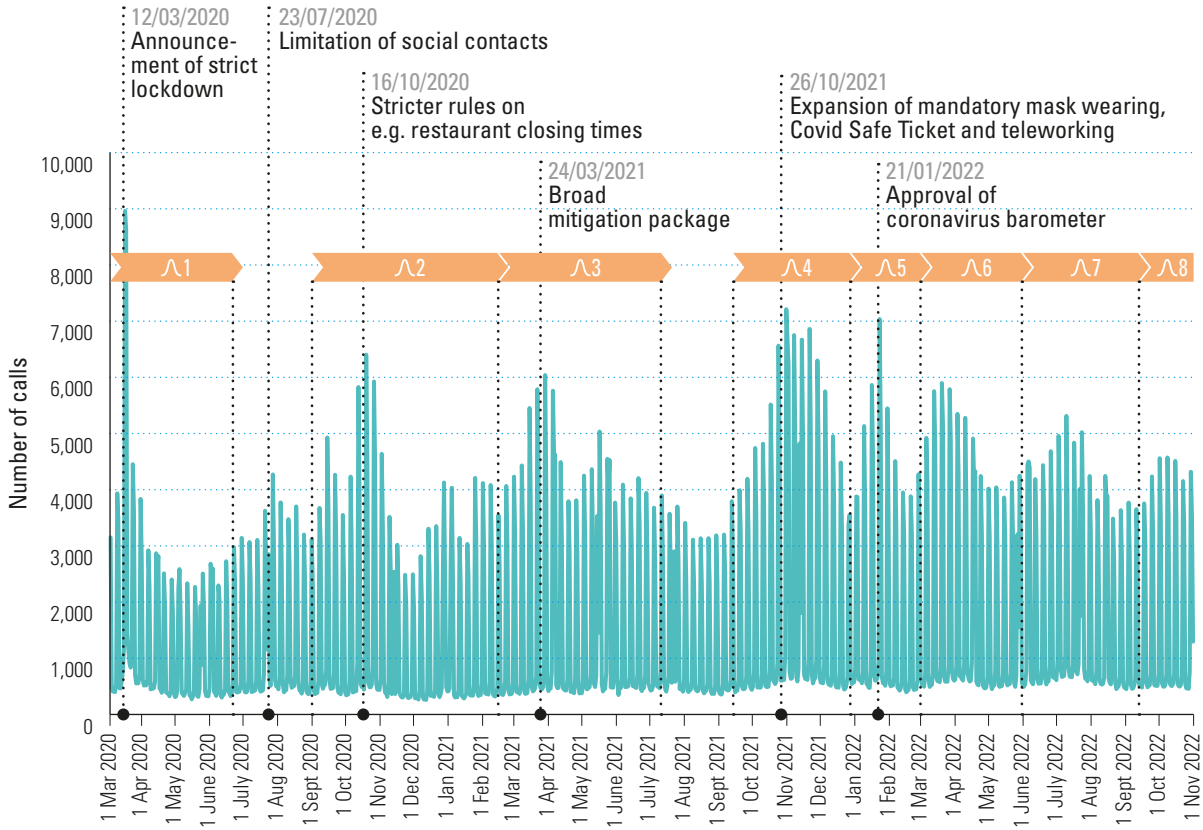
3. Impact of the pandemic on emergency assistance

3.1. Impact of the COVID-19 pandemic on 1733 calls

Telephone calls in the context of non-plannable care in Belgium are organised via 2 central telephone numbers. Calls for urgent medical assistance via 112 are responded to by an operator in an emergency centre. Non-urgent medical calls to 1733 are responded to by an operator in an emergency centre or forwarded to an out-of-hours GP service.

19 Patients are classified into 5 categories: 'Very low': the care workload amounts to max. 25% of the care workload for the average patient; 'Low': the care workload amounts to 25 to 50% of the care workload for the average patient; 'Medium': the care workload amounts to 50 to 150% of the care workload for the average patient; 'High': the care workload amounts to 150 to 300% of the care workload for the average patient; 'Very high': the care workload amounts to more than 300% of the care workload for the average patient.

CHANGE IN NUMBER OF DAILY CALLS TO 1733



The number of calls made to the number 1733 reached a record high over the weekend of 14 and 15 March 2020. This peak was due to the fact that many members of the public called this number for additional information on COVID-19 rather than because of a medical problem. The emergency centres experienced unprecedented levels of activity that weekend. Every effort was made to answer all calls. Additional staff were called in, support was provided by the medical directorates and helplines with GPs were set up.

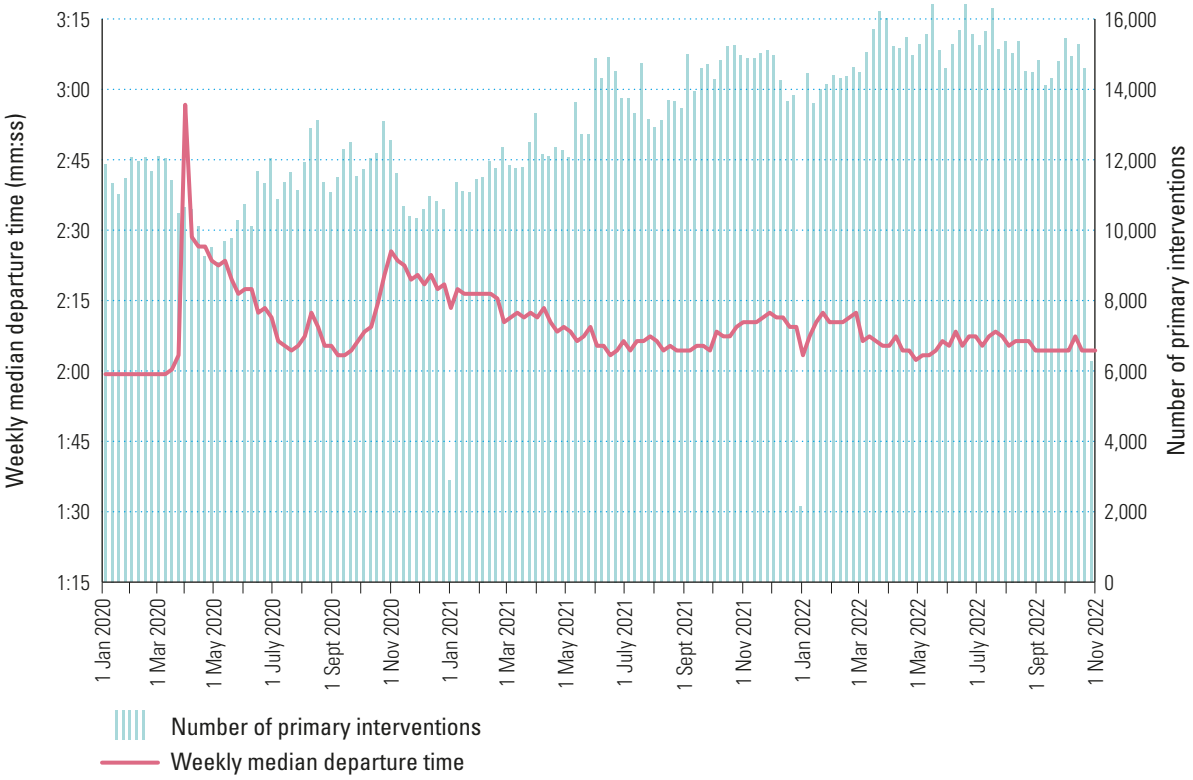
Following the weekend of 14 March 2020, it was decided to set up call-forwarding to the 0800 coronavirus information line when calls were made to the emergency centres. This would filter out the calls to the emergency centres where people only wanted to receive information on COVID-19. We observed that people continued to use the emergency numbers for a long time to obtain information on COVID-19, with questions about vaccinations, test results, etc.

After the peak in March 2020 we have observed a few more increases in the number of calls to the number 1733. These increases often coincide with an increase in the number of infections and with the moments at which decisions were taken and communicated by the Consultative Committee.

3.2. Impact of the pandemic on the intervention time of ambulances

When a call for emergency assistance is received in a 112 centre, an ambulance service is alerted to pick up the patient in question at the intervention site and transport them to the hospital. It was found that – primarily during the first wave of COVID-19 – the median ambulance departure time (i.e. the time between the call made to the ambulance by the 112 centre and the departure of the ambulance to the intervention site) increased significantly for a brief period[20]. This could be due to the fact that the emergency service workers had to put on their protective clothing just before their departure, which took more time due to the COVID-19 measures. As they got more used to this and the number of COVID-19 infections fell, the departure time once again decreased. After a slight increase during the second wave of COVID-19, the departure time remained stable.

IMPACT OF COVID-19 ON AMBULANCE DEPARTURE TIMES



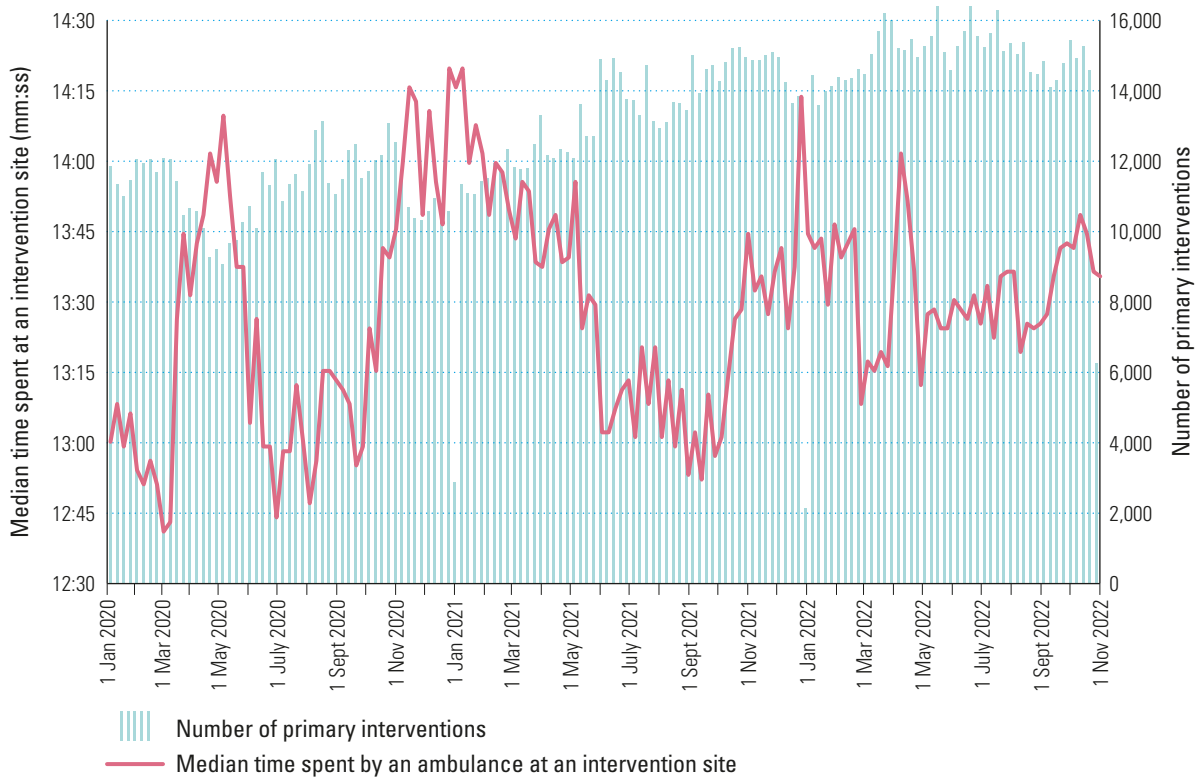
In addition, we can observe that the weekly median length of time that an ambulance crew is present at the intervention site shows a clear increase in the periods leading up to the various COVID-19 waves.[20],[21] This in turn can be explained by the fact that due to the higher risk of infection and the COVID-19 measures in force, a more cautious approach was taken in taking care of patients. This has an impact on the duration of interventions at the intervention site. Another explanation could be that fewer non-essential interventions were carried out during the COVID-19

20 Source: AMBUREG, Data and Policy Information Service, FPS HSFCE (6.48% of primary interventions were not taken into account due to missing values).
It should be noted that the interventions were taken into account until 31/10/2022. As a result, only a few days (i.e. 29/10/2022 – 31/10/2022) were included in the last bar in the graph instead of a full week. It should also be noted that there is a fall in the number of interventions in the 30/12/2020 and 31/12/2021 segments. This is because only one or two days were taken into account in these segments (30/12/2020 and 31/12/2020, on the one hand, and 31/12/2021, on the other hand).

21 Source: AMBUREG, Data and Policy Information Service, FPS HSFCE (23.60% of primary interventions were not taken into account due to missing values).

waves. Consequently, it could be assumed that there were more interventions for patients with more severe conditions, which could explain the rise in the weekly median.

IMPACT OF COVID-19 ON TIME SPENT BY AN AMBULANCE AT AN INTERVENTION SITE



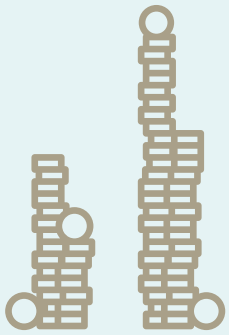
FUNDING

Financial support was provided by the federal government during the COVID-19 pandemic to address specific costs relating to the pandemic in the healthcare sector. Below are some of the initiatives in which the Healthcare Directorate of the FPS HSFCE was actively involved.

1. Funding for hospitals and their staff

The COVID-19 pandemic has had a major impact on the financial situation of hospitals and healthcare providers. The hospitals needed to implement emergency plans at short notice. Both increasing the admission capacity and increasing the capacity of the intensive care unit resulted in considerable additional costs.

In addition, non-essential care was postponed on several occasions, resulting in less revenue for the hospital and the healthcare providers through fee for service payment and fixed fees.



In 2020, an advance of €2 billion was granted to **general** and **psychiatric hospitals** in Belgium.

For this reason, the federal government decided in 2020 to provide financial compensation for hospitals and healthcare providers. To this end, advances totalling €2 billion were disbursed to general and psychiatric hospitals.

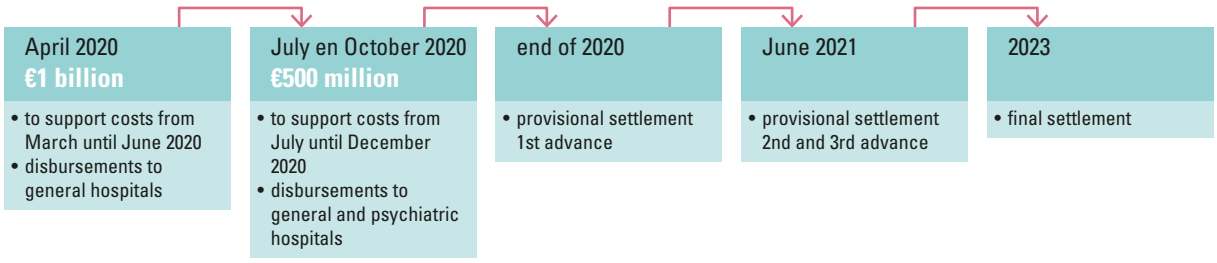
The aim of granting the advances was to support the hospitals in meeting their financial obligations, i.e. paying active staff members as well as paying invoices from suppliers and service providers on time.

The lump-sum payments are intended to provide support with the following:

- Exceptional costs as a result of the COVID-19 pandemic
- Ongoing costs
- Additional activities by healthcare providers
- Costs associated with the obligation to keep a percentage of the capacity available for COVID-19 care

The final funding will be calculated in 2023 taking into account the actual impact of COVID-19 on each hospital, and will be calculated and paid out in a collaboration between the FPS HSFCE and the NIHDI.

TIMELINE OF HOSPITAL FUNDING



Find out more about the specific rules for the disbursement of funding:

www.ejustice.just.fgov.be

A staff member working in a general or psychiatric hospital between 1 September and 30 November 2020 is entitled to a one-off incentive payment of €985 gross[22]. In addition, as compensation for the COVID-19 efforts made, care staff from the federal sector (including hospitals, district health centres and home nursing services) are also entitled to consumption vouchers worth €300 per person that can be used in the catering and events sector[23].

22 Source: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/faq_prime_dencouragement_pour_le_personnel_hospitalier-15_janvier_2021.pdf

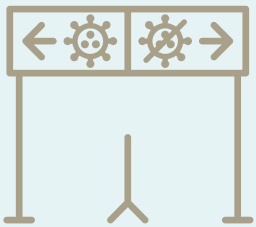
23 Source: Royal Decree of 22/12/2020 laying down the funding and arrangements for introducing a solidarity bonus in the federal healthcare sectors

Find out more about federal support for hospitals:

www.health.belgium.be

In order to continue to guarantee their optimal operation, hospitals were stimulated to keep the bed occupancy rate under control. Patients had to be optimally distributed across the various hospitals and their campuses. In addition, patients who no longer needed hospital care had to leave the hospital as soon as possible. Hospitals were entitled to compensation for the transportation of patients to achieve the above. In 2020 and 2021, hospitals recorded 21,106 and 21,363 trips, respectively. This includes both trips within and outside the hospitals, and the transportation of COVID-19 as well as non-COVID-19 patients. On average, a little over €2 million per year was paid out to compensate hospitals for the costs of this patient transportation. These amounts were paid out via the Financial Resources Budget.

2. Funding for triage and testing centres



In 2020 and 2021, **€56,479,000** and **€79,212,000**, respectively, were set aside by the NIHDI and the FPS HSFCE for the **funding of triage and testing centres** [24].

Funding is provided by the NIHDI and the federal government for both the start-up costs of the triage and testing centre and the medical costs, including medical coordination and compensation for doctors and nurses. Funding is also provided for administrative and support staff. In addition, a financial contribution for personal protective equipment was envisaged. The federated states contribute to the further operating costs of the centres[25].

24 Source: NIHDI

25 Source: Protocol Agreement concluded between the Federal Government and the authorities referred to in Articles 128, 130, 135 and 138 of the Constitution on the setting up, organisation and funding of triage and testing centres in the context of managing the COVID-19 crisis

3. Funding for the transitional care centres

The NIHDI provides a fixed fee for the services of doctors (coordination, follow-up, availability and direct care), nurses and healthcare assistants. The centres are paid on the basis of the number of hours worked. If care other than that of doctors and nurses is necessary, this will be organised through the regular channels. The patient's insurance provider will receive information about their client's stay in one of these centres.

€717,000 and €1,121,000 was paid out respectively in 2020 and 2021 by the NIHDI to **fund the transitional care centres**[26].

4. Funding for psychosocial support

4.1. Protocol agreement on the reinforcement of mental healthcare

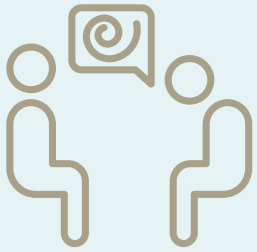
To respond to the increase in psychosocial problems associated with the COVID-19 pandemic, an extension of reimbursement for primary psychological care was approved. This way, in addition to adults, children, adolescents and over-65s are helped as well to consult a primary care provider for mild to moderate psychological problems.

In addition, within the Interministerial Conference on Public Health (IMC), the competent Ministers concluded a protocol agreement on the coordinated approach to strengthening the provision of primary psychological care. The agreement sets out several priority target groups, including children and parents in vulnerable families, young adults and people with existing mental health problems. An additional budget of €112.5 million was set aside for this effort. This equates to a total of 1,986 full-time equivalent (FTE) psychological care providers.

Find out more about the protocol agreement:

www.health.belgium.be

26 Source: NIHDI



An additional budget of
€112.5 million
was set aside to strengthen the **primary psychological care offering**.

This new convention on primary psychological care completes the range of care actors by offering accessible and fast help to vulnerable groups with mild to moderate problems. Indeed, it is desirable to detect the need for psychological care as early as possible. The additional offer is aimed at children and adolescents as well as adults and elderly.

The aim of the convention is to bring about change in access to care.

- On the one hand, by facilitating financial access. To this end, two care functions will be financed within this framework:
  - the primary psychological care function for support with mild to moderate problems
  - the specialist psychological care function for support with moderate to severe problems
- On the other hand, by facilitating access to an accredited clinical psychologist or remedial educationalist by making them available in citizens' immediate environment (i.e. focusing work on their natural environment). One wants to achieve that these care providers, in addition to the service provision in their practices, provide general care or even leisure activities at places where the vulnerable population goes for a purpose other than requesting psychological health support, e.g. an organisation for material or social assistance. This is motivated by the wish to offer assistance at a place that does not lead to stigmatisation. At a place that enables intersectoral and multidisciplinary collaboration with other care providers. These include, for instance, Public Social Welfare Centres, the Child and Family Agency, assistance in an open environment, homework schools, community centres, student guidance centres and GP practices.

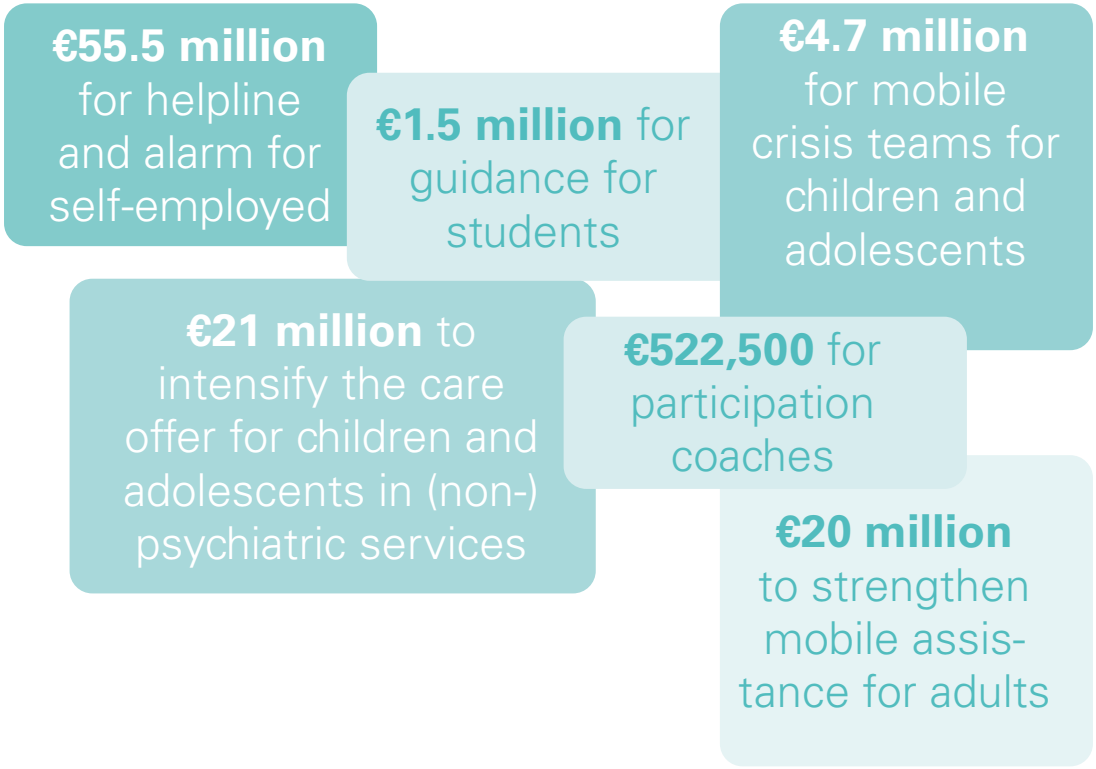
In 2022, the various networks for mental healthcare have entered into new agreements with care providers based on a needs analysis of their area of activity within the framework of the protocol agreement. In the meantime, one can see that the number of people that have made use of the offer of primary psychological care is increasing.

Find out more about the agreement for the reimbursement of psychological care:

www.riziv.fgov.be

4.2. Temporary measures during the pandemic

As the development of this convention takes time, a number of temporary measures aimed at vulnerable target groups have already been taken in this context. Indeed, various studies have shown that the mental well-being of adolescents and students, people living alone and professionals that are most affected by the pandemic (e.g. those working in healthcare, catering, the cultural sector) is under the greatest pressure.



In order to specifically meet the psychological needs of these most vulnerable groups, the following measures have been taken:

- Psychological care for self-employed with psychological needs through e.g. a free helpline and/or an alarm that is activated by explorers (e.g. trustees in bankruptcy, banks, business one stop shops, social insurance funds for self-employed, social secretariats and care providers) or clinical psychologists and remedial educationalists who regularly come into contact with self-employed persons. An annual budget of €55.5 million was set aside for this. This measure was in place until 28 February 2022.

- From 15 April 2021 to 31 December 2021, €1.5 million was set aside for guidance for students in colleges and universities. Group sessions with an emphasis on stress control and reinforcing the ability to cope were organised in order to prevent the development of psychological problems.

- Since February 2021, the measure was taken to provide faster assistance to children, adolescents and young adults with acute psychological problems or adolescents in a crisis situation by reinforcing the mobile crisis teams of the networks for mental healthcare for children and adolescents.

    - the total budget for the mobile teams was increased by 50%;
    - the operating resources for the networks by 75%;
    - the resources for network psychiatrists by 25%.

This way, the capacity for mobile crisis assistance was expanded considerably in the short term through an additional budget of €4.7 million, which is the equivalent of approximately 50 FTE.

- In addition, it was decided in April 2021 to intensify the residential care offer for the assistance of children and adolescents with serious and complex psychological problems by increasing the personnel resources for psychiatric services for children and adolescents. Such intensification allows the personnel to take care of the transfer of care from the residential setting to the home or substitute home environment. The aim of this is to optimise the continuity of care for children and their families and reduce the length of stay in psychiatric services for children and adolescents. A total of 212 FTEs were financed. At the same time, it was also decided to increase the care capacity for assistance to children and adolescents with psychological problems in non-psychiatric hospital services by using so-called liaison teams from the psychiatric services for children and adolescents to e.g. paediatric services. A total of 23 teams of 2.70 FTEs each were financed. An additional annual budget of just over €21 million was set aside for these measures.

- In addition, participation coaches were added to the networks for mental healthcare for children and adolescents to increase the participation of adolescents and their environment in the development of their own care pathways and in policy at the level of the institution, the network and the government. An annual budget of €522,500 was set aside for this.

- It was also decided to reinforce the mobile assistance of the networks for mental healthcare for adults by 25% for the elderly target group. In doing so, the aim is to pay special attention to the socially and economically vulnerable and to those who tend to avoid care. To this end, mobile, outreaching and multidisciplinary care will be provided. An annual amount of more than €20 million was set aside for this, which allows to increase the mobile teams by 244 FTEs.

The latter 4 measures currently continue unabated.

Furthermore, numerous other actions were taken during the pandemic to strengthen mental healthcare provision, including:

- Reimbursement of video consultations by psychiatrists;
- Remote aftercare following admission to a psychiatric hospital[27];
- Possibility of partial hospitalisation at the patient's home[28];
- Awareness-raising among primary healthcare professionals to encourage the safe use of psychopharmaceuticals;
- Training of hospital staff to improve the care of individuals with alcohol problems;
- Psychological support for hospital staff;
- Furthermore, additional resources were granted to the Flemish Cross for their cooperation in the management of the health crisis, including for offering psychosocial support in the COVID-19 call centre intended for the general public.

27 Find out more about remote aftercare via NIHDI (fgov.be)

28 Find out more about partial hospitalisation at home via NIHDI (fgov.be)

4.3. Project calls

In the spring of 2022 a call was launched to the networks for mental healthcare for children and adolescents to design 6 new sites for the target groups children, adolescents and young adults. These networks can submit proposals for the reinforcement of assistance to children, adolescents and young adults within their area of activity. Around €35 million is being invested in this. It is hoped to be able to meet the most urgent needs in each province. Certain flexibility is permitted in order to invest the budget made available where it is most needed. Based on a needs analysis, a decision will be made on how exactly the additional resources, complementary to the local offer and initiatives already present, will be used.

Find out more about this call:

www.health.belgium.be

Furthermore, a project call was launched to the networks for adults to submit project proposals on the 'Intensification of residential care', so that in each network at least 1 High Intensive Care service is developed. This call implements the decision of the coalition agreement of 30 September 2020 to deploy more staff in psychiatric care programmes than provided for in the current rules for staff. An investment of €15 million has been planned for the deployment of an additional 150 staff and reinforcement with 193 hours of medical work.

More information:

Working group on intensification of residential care

5. Funding for ambulance services

In the context of tackling the pandemic, 22 ambulance services added an addendum to their agreement with the FPS HSFCE in 2020. On the basis of this addendum, a standard allowance of ± €12,000 was granted for a period of 8 weeks for each on-call unit within the ambulance service that was available 24/7. In addition, a one-off amount of €8 million was divided between the ambulance services in the context of the COVID-19 pandemic.

QUALITY

1. Support for psychosocial well-being

In the context of the Psychosocial Intervention Plan (PSIP)[29], a **Psychosocial Coordination Committee (PSCC)** was set up by the FPS HSFCE in response to the COVID-19 pandemic.

The aim of this committee is to bring together representatives from all the services and bodies involved, to agree on a **joint strategy**, and to work **together as a team** in order to set up psychosocial support services. Through the PSCC, initiatives were coordinated so that a consistent message was always communicated and the actions would be complementary.

The overall objective was to encourage self-care, care for each other and improving the resilience of both the individual and society.

A lot of emphasis was placed on the importance of **clear communication**:

- A **communication campaign** was launched **with tips** on dealing with stress, both for the general public and the specific group of care providers;
- An **e-learning** module was set up to support psychosocial care providers;
- The information was communicated centrally through fixed channels in order to maintain an overview of all initiatives. The gateway for information on COVID-19 and psychosocial well-being is the website www.info-coronavirus.be. Information specifically for healthcare providers has been compiled on the website of the FPS HSFCE.

Find out more about the organisations and initiatives on psychosocial well-being during the COVID-19 pandemic:

www.info-coronavirus.be

2. Belgian manual for medical regulation

Calls to 112 and 1733[30] requiring medical intervention are handled by the operators of the 112 centres via the Belgian Medical Regulation Manual. This manual provides an integrated set of medical protocols to uniformly determine the severity level of emergency calls by emergency centre operators and maintain the quality of service. It offers guidelines to staff members as to

29 You can find more information about the Psychosocial Intervention Plan in 'Key data in healthcare – Emergency medical and psychosocial assistance'.

30 1733 is a central telephone number in Belgium to reach an on-call GP in the event of non-urgent medical assistance (see also the chapter 'Care activity')

which resource (MUG, PIT, ambulance, on-call service, house call or own GP [31]) should be sent out or which actions should be recommended in a specific situation.

In the context of the coronavirus crisis, a new protocol was temporarily developed to respond adequately to calls from people potentially infected with COVID-19. Depending on the progress of the scientific knowledge on the virus, this medical protocol was revised and corrected several times, taking into account the Sciensano guidelines.

The 112 medical directorates and/or deputy medical directorates and the nursing regulators, who are part of the Emergency Assistance department of the FPS HSFCE, are present in the emergency centres to support and advise operators. Throughout the crisis, the medical directorates accompanied the 112 operators in monitoring the evolution of the COVID-19 protocols to ensure efficient and effective handling of calls for assistance in relation to coronavirus.

More information on the Belgian Medical Regulation Manual:

www.health.belgium.be

3. Distribution of protective equipment to healthcare professionals working in the outpatient sector

3.1. Identification of the healthcare professionals

During the COVID-19 pandemic, healthcare professionals have needed protective equipment so that they can safely care for patients. These protective materials are distributed both within hospitals and by employers within healthcare institutions. However, it is also essential to provide the necessary equipment to healthcare professionals active in the outpatient sector.

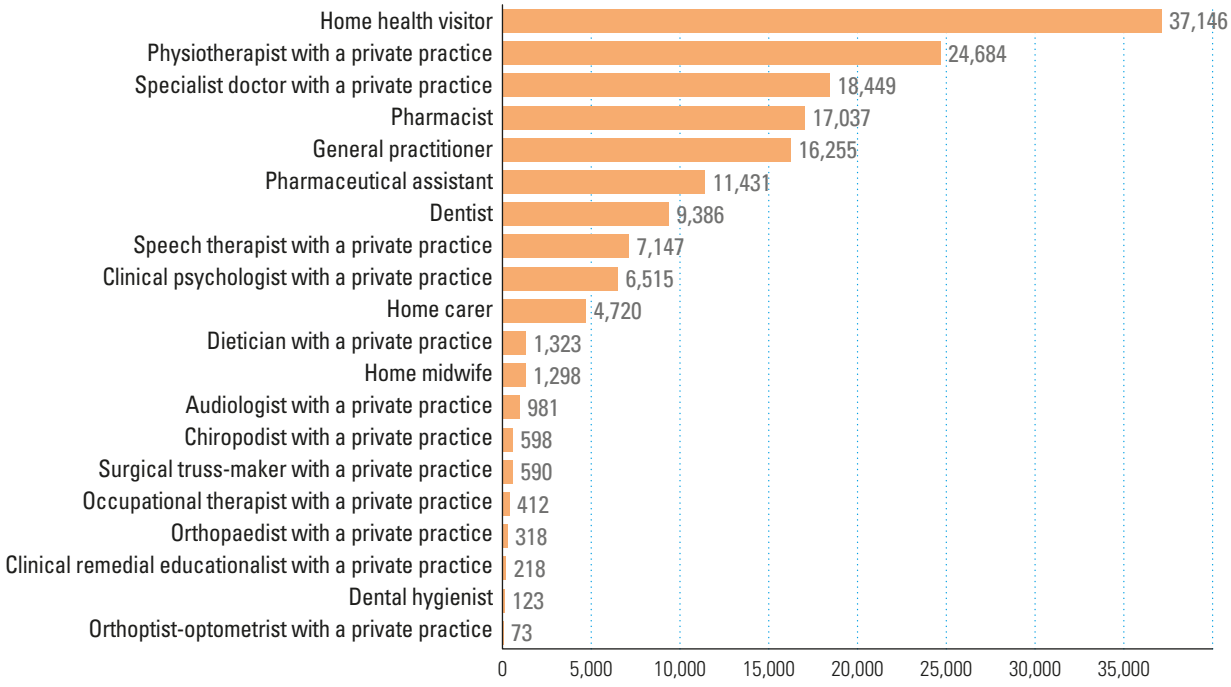
To ensure efficient distribution of this equipment, the first step was to identify these healthcare professionals. The 'Healthcare professions & practice' department of the FPS HSFCE compiled a list of healthcare professionals working in the outpatient sector. To this end, various data sources were brought together from the FPS HSFCE, the NIHDI, the National Institute for the Social Security of the Self-Employed (NISSE) and the National Social Security Office (NSSO).

31 See 'Key data in healthcare – Emergency medical and psychosocial assistance' for more information on how the different channels work.

In 2021, there were
158,704 **healthcare professionals** active in the **outpatient sector**.

Based on this exercise, a list of 158,704 healthcare professionals active in the outpatient sector was drawn up.

NUMBER OF CARE PROVIDERS ACTIVE IN AMBULATORY CARE
(MARCH/APRIL 2021)

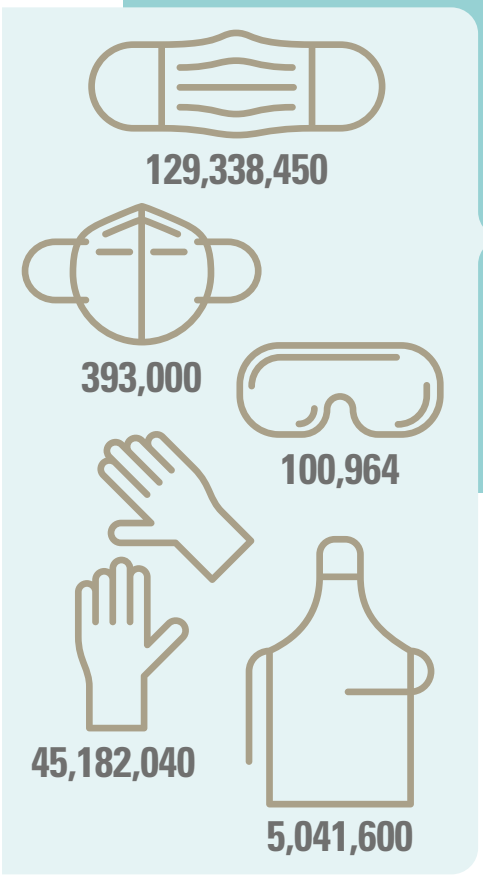


In order to simplify the identification of the active healthcare professionals in future, the Act on high quality in healthcare practice (22 April 2019) establishes that a register should be kept (Art. 42). This should include a general description of the healthcare provided by each healthcare professional, the place where this care is provided, and any collaboration agreements with other professionals. The register will contain all healthcare professionals authorised to exercise their profession in Belgium and will in future allow us to know who is active in which sector and which location.

It will include appropriate means of communication in the event of a crisis. This will allow us to easily contact and deploy the relevant professionals in a future crisis.

3.2. Distribution of protective equipment

The Public Health Emergencies Service of the FPS HSFCE coordinated the distribution of protective equipment. At the start of the pandemic, the equipment was only supplied to healthcare professionals who remained active. Since May 2020, the equipment has been distributed to all healthcare professionals, in order to restart outpatient activity.



Distribution of **protective equipment** to healthcare professionals in the **outpatient sector** between March 2020 and April 2021.

The equipment was supplied by the Ministry of Defence to all the provinces, after which the governors took care of subsequent distribution at local level. A strategic stockpile was also built up. The content of the stockpile was determined on the basis of advice from the consultative bodies for each healthcare profession.

The stockpile was initially distributed to the professions most at risk, and then expanded according to a detailed plan for all health professions. In this context, an app was developed so that any healthcare professional could register to obtain equipment.

Find out more about recommendations and the strategic stockpile of protective equipment in the outpatient care provision:

www.health.belgium.be

4. Ensuring nursing care

Since the start of the COVID-19 pandemic, the nursing staff and other healthcare professionals have worked under great pressure. As a result of the continued flow of COVID-19 patients, there has been a risk of nursing staff shortage.

For this reason, the decision was made that some nursing activities could be carried out by individuals who are not legally entitled to do so, such as students, dentists and midwives. This was an exceptional and temporary measure during the COVID-19 pandemic. These activities may only be carried out under strict legal conditions[32]. For example, the activities could only take place under the supervision of a coordinating nurse or training was required. As such, the continuity, quality and safety of the nursing care were guaranteed as much as possible.

Some of these exceptional measures were extended until 1 July 2022 by the Act of December 2021[33], by which the measures were limited to conditions for specific services (e.g. testing patients and administering vaccines).

5. Support with testing and vaccination by pharmacists

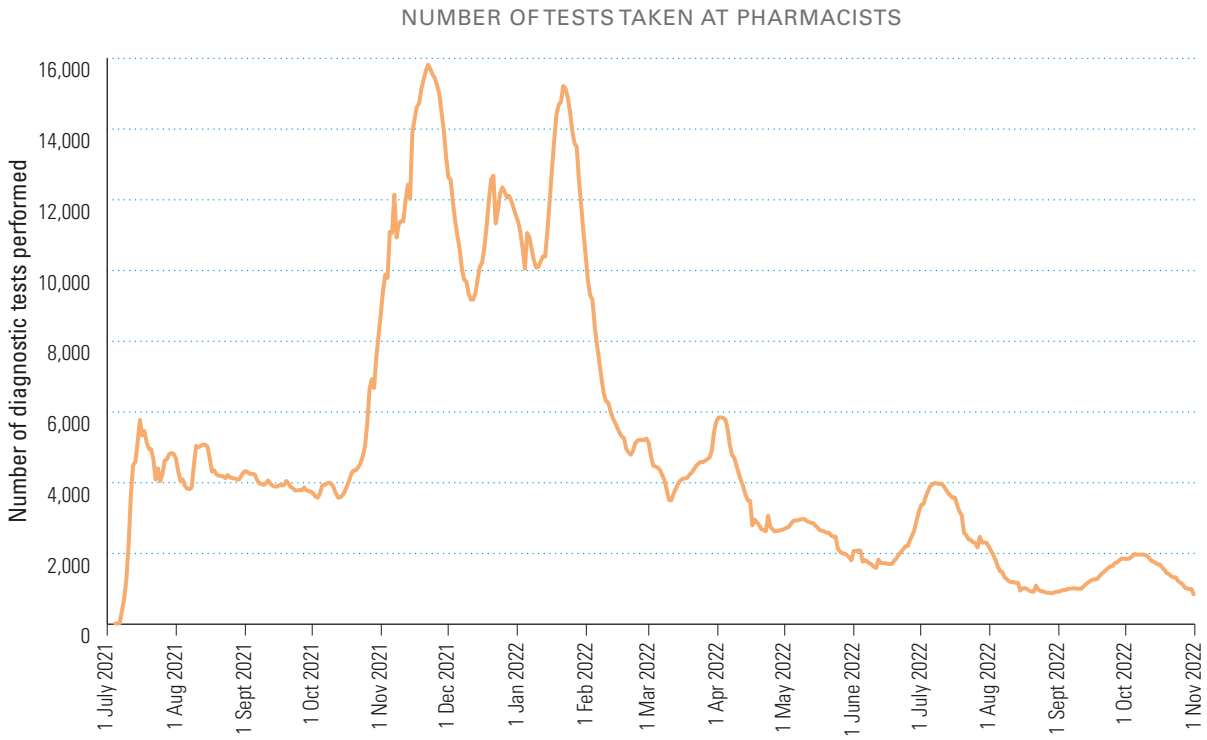
An Act[34] was amended to include new operations that could be performed by pharmacists working in public pharmacies. This Act specified the strict conditions and circumstances under which these acts could be performed, including following training.

Since then, pharmacists have been authorised to prescribe and administer a COVID-19 vaccine. However, the vaccine may only be prescribed if it is administered immediately in the pharmacy. In addition, pharmacists are also authorised to prescribe adrenaline and to administer it subcutaneously or intramuscularly in case a patient should suffer an anaphylactic shock after administration of the vaccine.

Furthermore, since mid July 2021, pharmacists are temporarily authorised to take samples for a rapid antigen test and to communicate the results of this test to the competent body. This applies only for people from the age of 6 who do not have symptoms of COVID-19 and who need a COVID-19 certificate for travel or an event. Since 1 November 2021, pharmacists can also carry out tests for travellers returning from a red zone and for people with COVID-19 symptoms. Pharmaceutical-technical assistants may also carry out these acts under the responsibility and supervision of a pharmacist.

32 Act of 4 November 2020 on various social measures following the COVID-19 pandemic
33 Act of 23 December 2021 amending the Act of 4 November 2020 on various social measures following the COVID-19 pandemic
34 Consolidated Act of 10 May 2015 on the exercise of healthcare professions

The graph below shows the number of tests taken by pharmacists. Here, increased activity can be observed from November 2021 to early February 2022.



6. Temporary increase in the number of laboratory workers

With each new COVID-19 wave, the need to provide sufficient testing capacity in order to be able to take the necessary measures in due time increased. For this reason, it was decided to exceptionally authorise persons to carry out tests in order to be able to diagnose cases of COVID-19.[35] Once again, this could only take place under strict conditions. For instance, the persons concerned had to have a specific diploma and follow additional training. Furthermore, the acts had to be entrusted by a doctor or pharmacist specialised in clinical biology, and take place under their supervision.

This measure made it possible to employ more people in the laboratories. This way, the exceptionally high need for analyses during the COVID-19 pandemic could be met.

35 Royal Decree of 21 September 2021 by which persons who are not legally authorised to practice medicine are granted permission, in the context of the COVID-19 epidemic, to carry out certain laboratory tests

7. Hospital Outbreak Support Team

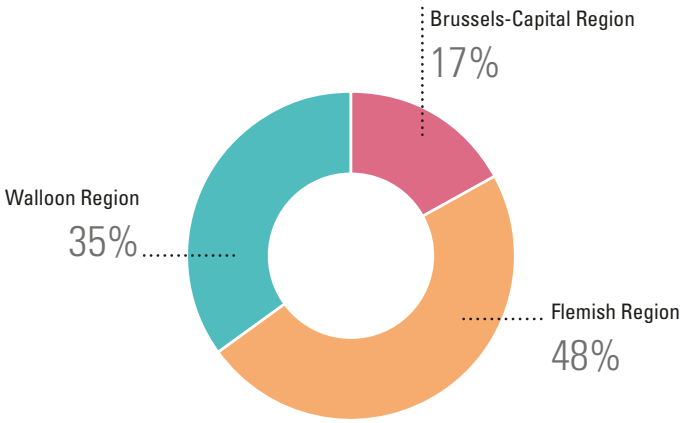
7.1. Context

The fight against the COVID-19 pandemic highlighted the need to strengthen collaboration between hospitals, residential institutions and primary care health professionals.

In March 2021, the FPS HSFCE launched a call in this respect, inviting general and university hospitals to take part in a pilot project called 'Hospital Outbreak Support Team (HOST)', aimed at, on the one hand, improving the management of epidemics and cluster outbreaks, and, on the other hand, supporting hygiene teams and management groups for antibiotics therapy in the prevention of and fight against infections and in antimicrobial management.

In 2021, 21 pilot projects with multidisciplinary HOST teams had already been created. In 2022, 3 new pilot projects have been started, which include the entire Belgian hospital landscape.

DISTRIBUTION OF THE HOST TEAMS BY REGION



7.2. Achievements in the first year of the pilot project

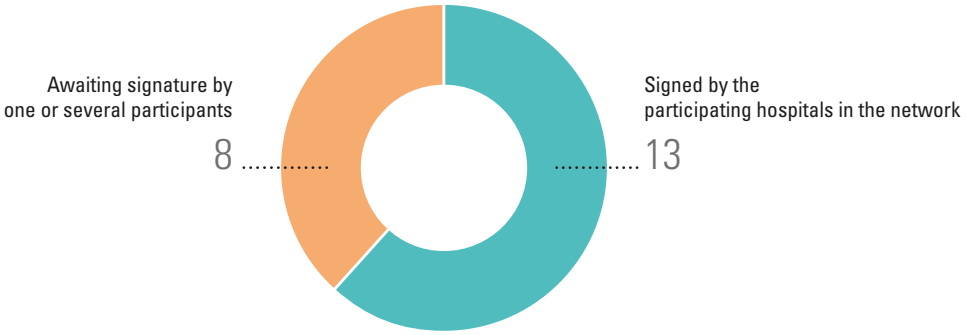
The first year of the pilot project was aimed at:

- Specifying the coordination between the hospitals involved via cooperation protocols;
- Creating a multidisciplinary HOST team that complies with the minimum composition criteria[36];
- Creating a telephone hotline that can be reached both by hospitals and by other residential care centres.

Despite the difficult start due to the busy period during the COVID-19 pandemic, most participating networks met the above objectives. All participants said they had already drawn up a cooperation agreement, and for two out of three projects this had already been signed by all participating hospitals.

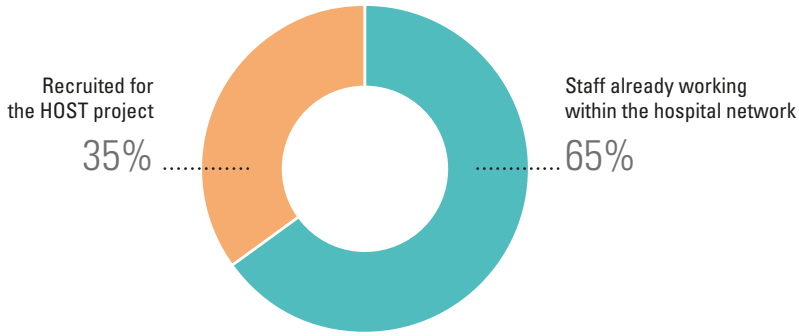
36 A project manager (0.5 FTE), a HOST coordinator (1 FTE), a nurse (1 FTE), a hospital pharmacist (0.5 FTE).

EXISTENCE OF A COOPERATION AGREEMENT



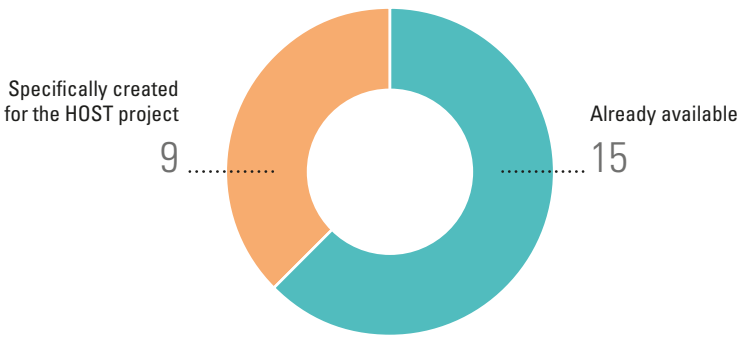
Where the creation of a HOST team is concerned, all participating networks reported that they had managed to set up a team: in 16 networks, the minimum requirements for this were met, and in 8 networks additional requirements were met. In 2021, 35% of the professionals needed were recruited. The other vacancies were filled by people who were already working within the hospital network.

PERCENTAGE OF HIRES



The majority of the HOST teams indicated that they had set up a 24/7 telephone line. However, discussions are still ongoing between the federal authorities and the federated entities to clarify the role and scope of this 24/7 service. In these discussions, it is attempted to provide an offer that meets the needs of the various regions and residential care centres, while respecting the powers of each party.

AVAILABILITY OF A 24/7 TELEPHONE LINE



7.3. Collaborations and exchanges

An important element of the success of this pilot project lies in the communication between the actors in the field, in the hospital management and in the regional and federal authorities. However, in the first year of the project, the pandemic made it impossible for the various actors to meet. For this reason, individual intervision sessions were set up by the Belgian Antibiotic Policy Coordination Committee (BAPCOC), where support was provided to the HOST teams. This initiative has led to the publication of a web page with FAQs.

On the other hand, dialogue sessions between the BAPCOC team and the different regions were set up in order to define their specific roles and tasks. In particular, the complementarity between the OST and HOST teams was defined. The regional authorities also contacted the newly created HOST teams to brainstorm about the best form of cooperation to meet specific local needs.

More information:

BAPCOC page dedicated to the project

federal public service
HEALTH, FOOD CHAIN SAFETY
AND ENVIRONMENT