KEY DATA IN HEALTHCARE

COVID-19

period March 2020 - June 2021

Edition 2021

.be

Colophon

SUBJECT

In this publication, we decided to focus on the remits in which the Directorate-General for Healthcare of the Federal Public Service for Health, Safety of the Food Chain and the 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.

EDITORIAL COMMITTEE

The members of the Directorate-General for Healthcare.

RESPONSIBLE PUBLISHER

Tom Auwers,
Galileelaan 5/2 – 1210 Brussels

CONTACT INFORMATION

federal public service
HEALTH, FOOD CHAIN SAFETY AND ENVIRONMENT

Directorate-General Healthcare

Galileelaan 5/2 – 1210 Brussels
T. +32 (0)2 524 97 97 (Service Center Health)

This document is available on the website of the Federal Public Service Health, Food Chain Safety and Environment:

www.health.belgium.be
and **www.healthybelgium.be**

Legal deposit: D/2022/2196/25

FOREWORD

Dear reader,

You are holding in your hands the fourth edition of the 'Key Data'. This time around it is a special edition on a theme that has touched everyone in recent months: COVID-19. The virus that caused a pandemic and led to serious disruption to our daily lives.

For months on end, healthcare providers from different sectors unfailingly gave their all in order to provide the public with the best possible care. At the policy level, various structures and bodies were set up to manage the pandemic in our country. Many individuals in the various authorities have been working every day to monitor the evolution of the spread of the COVID-19 virus, taking into account scientific evidence and formulating appropriate measures.

In this publication, we decided to focus on the remits in which the Directorate-General for Healthcare of the Federal Public Service for Health, Safety of the Food Chain and the 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. These actions were all taken in close cooperation with other services within our FPS and our partner organisations such as the NIHDI and the FAMHP. This publication covers the period from the start of the pandemic in March 2020 up to and including June 2021.

The aim of the 'Key Data' is to provide an overview of the large amounts of data and information available within our services. By sharing our knowledge with you, our aim is to lay the groundwork for further analysis and interpretation. For example, this publication presents several findings on the impact of the pandemic on emergency assistance and data on the reduction of non-essential care that may provide a starting point for future policy-making.

Earlier publications on the operation of 'General hospitals', 'Mental health care' and 'Emergency, medical and psychosocial assistance' have already emerged. We plan to publish an updated edition on each topic in the coming years. In this way, we will be able to highlight the trends and evolutions.

In any case, I hope you enjoy reading this edition.

Annick Poncé,
Director General ad interim, 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 the crisis management was declared in Belgium, meaning that from that point on, the COVID-19 pandemic was managed at the 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].

1.1. Strategic and policy bodies

- The **National Security Council** is a federal body consisting essentially of the Prime Minister and 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 in 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 on Public Health** (see below).

- The **Federal Coordination Committee (COFECO)** is chaired by the National Crisis Centre 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 should maintain relations with experts and social partners. In addition, the Commission is competent for formulating proposals for reforming the various consultation structures and thus simplifying the fight against the crisis. Finally, the Commission must acquire new insights about the virus with a structured approach, and has to monitor the social, economic and societal impact of the measures taken. In this way, the Commission can provide support for policy decisions and their implementation.

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 includes experts from Sciensano, federal and regional health authorities. Since November 2020, this body has taken over the remit of Celeval (see below) with regard to analysing epidemiological risks, and since then has submitted its opinions to the Governmental Corona Commission.

1 Source: https://www.info-coronavirus.be/en/what-is-the-government-doing-about-it/ and https://centredecrise.be/fr/newsroom/covid-19-une-gestion-de-crise-collegiale-et-complexe

- 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-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, RMG and the scientific committee. On this basis, the unit advised the authorities on measures to be taken to stop the spread of 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.

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 Centre (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.

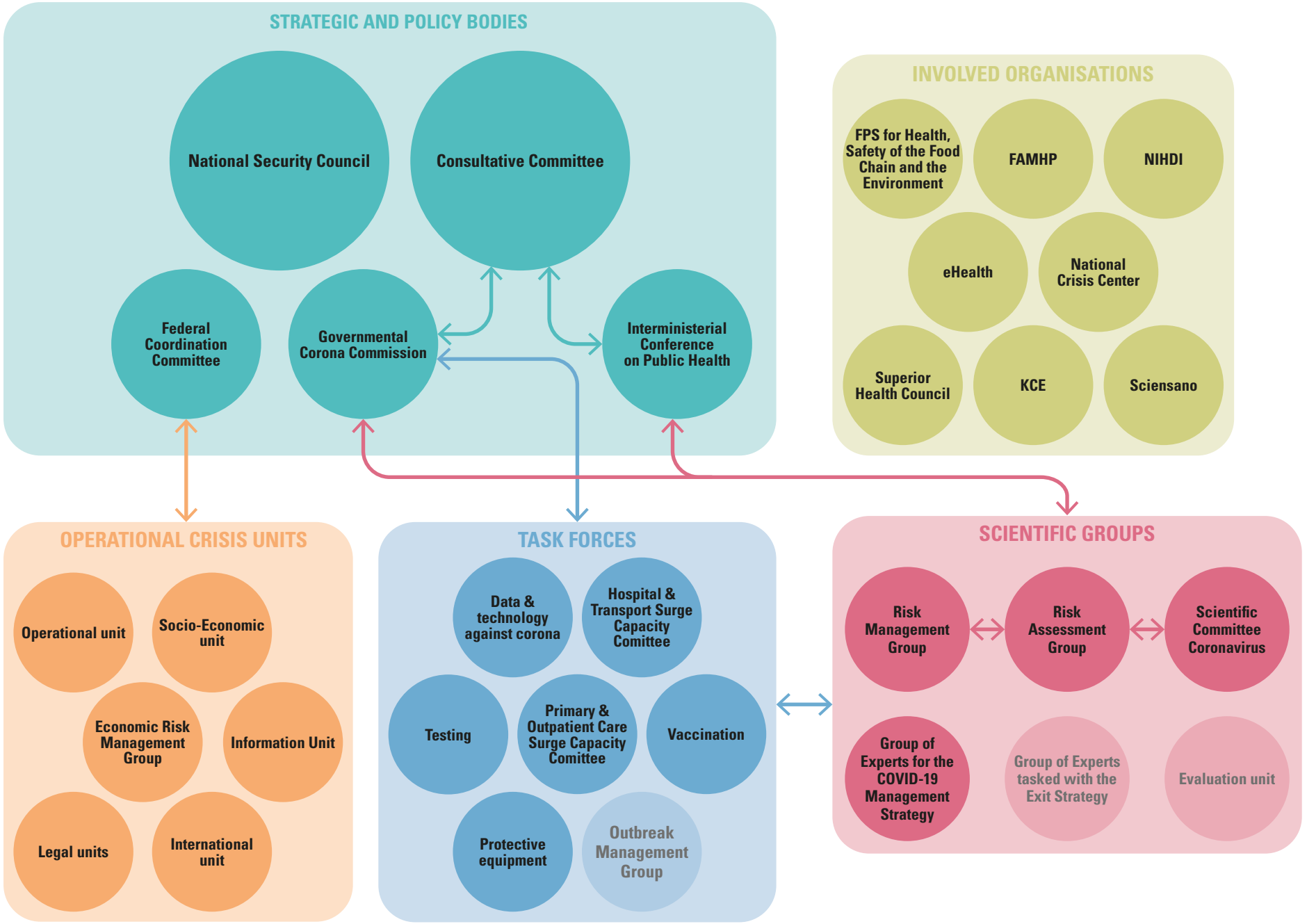
- The **Information Unit (INFOCEL)** is co-chaired by the FPS-HSFCE and the NCCN. This unit is responsible for consistent communication towards the public with regard to the pandemic.

- 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 the 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 corona) 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, the flow of patients in and out of 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 for Healthcare of the FPS-HSFCE. The Committee focuses on inter-federal cooperation to provide streamlined communication and approaches.

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, etc.) are coordinated and appropriate.

OUTBREAK MANAGEMENT GROUP

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 measures and contamination in residential organisations such as residential care centres, institutions for people with a disability, reception centres for migrants, etc.

The first objective of this working group was to make a joint analysis of the situation in the aforementioned 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 residential care centres, 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. Since 1 March 2020, this Conference has convened over 100 times in video meetings on the subject of the COVID-19 crisis with the aim of:

- closely monitoring the evolution of the pandemic;
- regulating the testing strategy;
- coordinating the vaccination strategy;
- streamlining communications as much as possible.

Since October 2020, the IMC has worked closely with the Governmental Corona Commission.

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

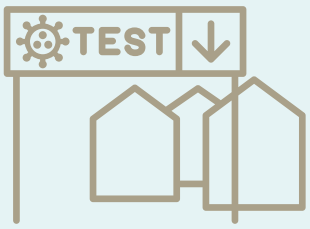
Several centres were set up in the context of the COVID-19 pandemic. The triage and testing centres and the 'transitional care' centres are discussed below.

2.1. Triage and testing centres

The triage and testing centres have a dual function[2]:

- 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.

- **Testing** was assigned to the centres as a second function to better meet the needs of public 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.



127 triage and testing centres have been set up and an **alternative testing centre** or **test village** has been set up in **12 locations**[3].

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.

2 Source: Royal Decree of 13/05/2020 no. 20 introducing temporary measures in the fight against the COVID-19 pandemic and to ensure the continuity of care in the compulsory health care insurance.

3 Source: DG Health Care, FPS HSFCE (31/05/2021)

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 traditional testing circuit, organised in and by clinical laboratories. The federal platform is responsible for supplying test material, collecting and transporting the tests to the laboratories and forwarding the test results. As of 20 April 2021, a total of 60 centres were using the federal platform. The other centres work with a hospital laboratory or a private laboratory. In such cases, the laboratories themselves are responsible for supplying test material, transporting the tests performed and forwarding the results. A centre can switch to the federal platform if the laboratory can no longer 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[4]. 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. They could recover there and receive the necessary care and support before returning home.

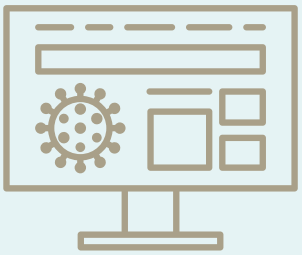
The transitional care centres were staffed by (general) practitioners, nurses and healthcare assistants, and financed by the NIHDI. The federated states were responsible for providing the necessary

4 Source: Royal Decree of 13/05/2020 no. 20 introducing temporary measures in the fight against the COVID-19 pandemic and to ensure the continuity of care in the compulsory health care insurance.

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.

During the period from March-April to May-June 2020, 6 centres were active in Flanders and 1 in Wallonia. To meet new needs, 8 new centres were opened in Flanders and 3 in Wallonia in November 2020.

3. Online health website mijngezondheid.be



5 million visitors of **online-portal** in 7 months.

The website mijngezondheid.be has communicated information about COVID-19 since October 2020.

This information is divided into 2 sections:

- **Information:** this section contains links to other websites with official information on COVID-19
- **Personal data:** in this section visitors can find various features which are supplemented according to the current situation.
  - Applications relating to taking a test: e.g. making an appointment, consulting the test result or requesting a quarantine certificate;
  - Information about vaccination: e.g. 'My vaccination details' or 'Report a side-effect';
  - Features relating to travelling abroad: e.g. 'European COVID certificate' or 'Request a free PCR test'.

Almost 5 million visitors were registered on the website over a period of 7 months[5] and the applications relating to COVID-19 were clicked more than 4 million times during this period.

5 Over the period from November 2020 to early June 2021

CARE ACTIVITY

Throughout the COVID-19 pandemic, countless healthcare workers dedicated themselves day in and day out to treat patients with COVID-19. This chapter outlines the actions taken by the HTSC to maintain capacity within hospitals and the steps taken as regards transporting COVID-19 patients. Furthermore, the impact of the pandemic on emergency assistance is discussed.

Given the extensive reporting on the epidemiological data regarding the spread of COVID-19 in Belgium, we have opted not to include them in this report but refer you to the website of Sciensano.

Find out more about the epidemiological data regarding COVID-19 (Dutch and French only):

covid-19.sciensano.be

1. 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 Organisation section) 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 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 admission was needed in order to effectively monitor the situation in the Belgian hospitals. The hospitals registered the admission data and the free 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.

1.1. 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.

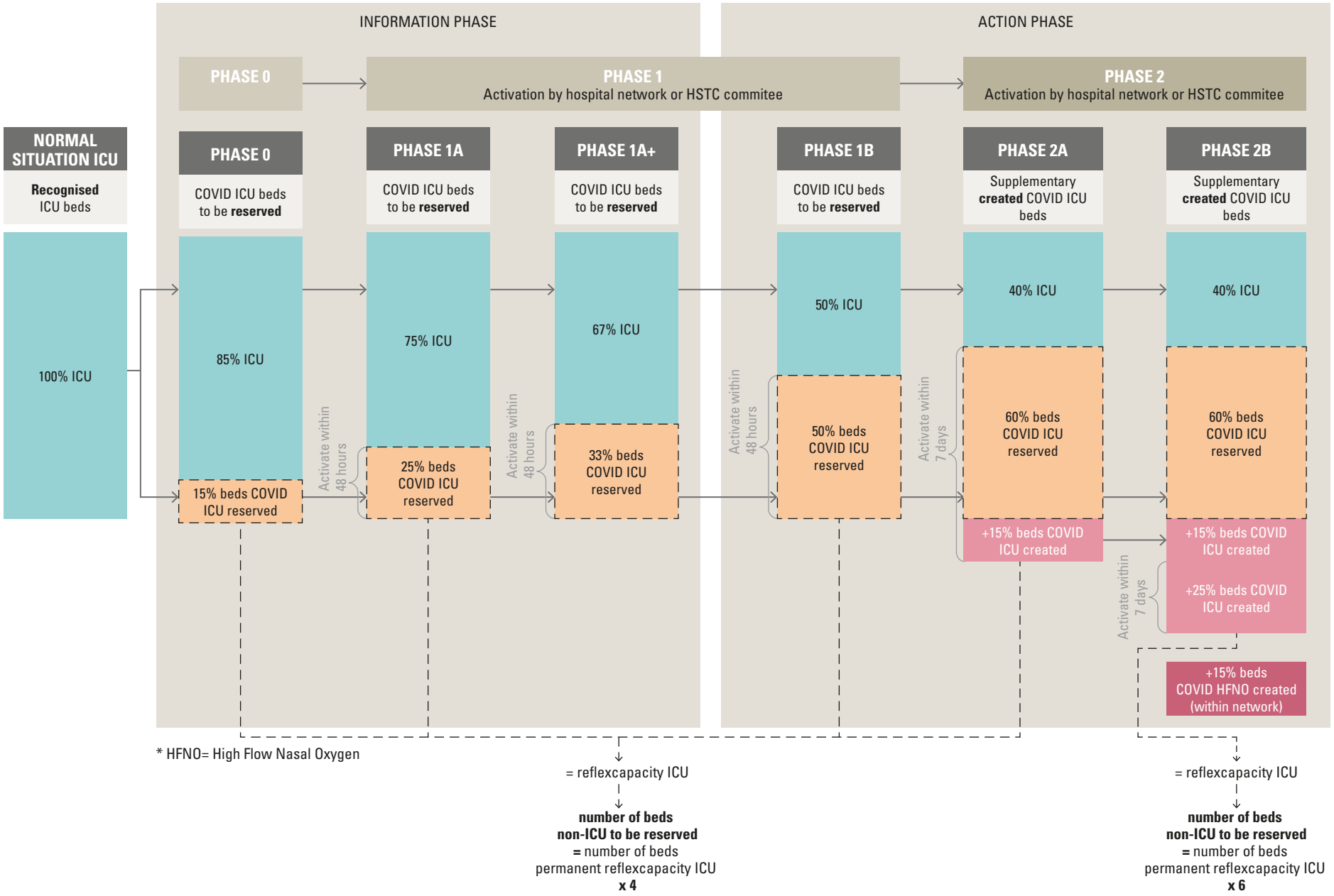
The plan is divided into **2 main phases**:

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 on 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) on the other services 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 11/03/2021



1.2. 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 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 for restart were set out:

- Restart of consultations, home hospitalisation activities and the activities of mobile teams
- Restart of non-surgical day hospital activities (e.g. geriatrics, psychiatry)
- Restart of surgical day hospital activities not using intensive care
- Restart conventional hospitalisations not using intensive care
- Restart activities using 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 (Dutch/ French only):

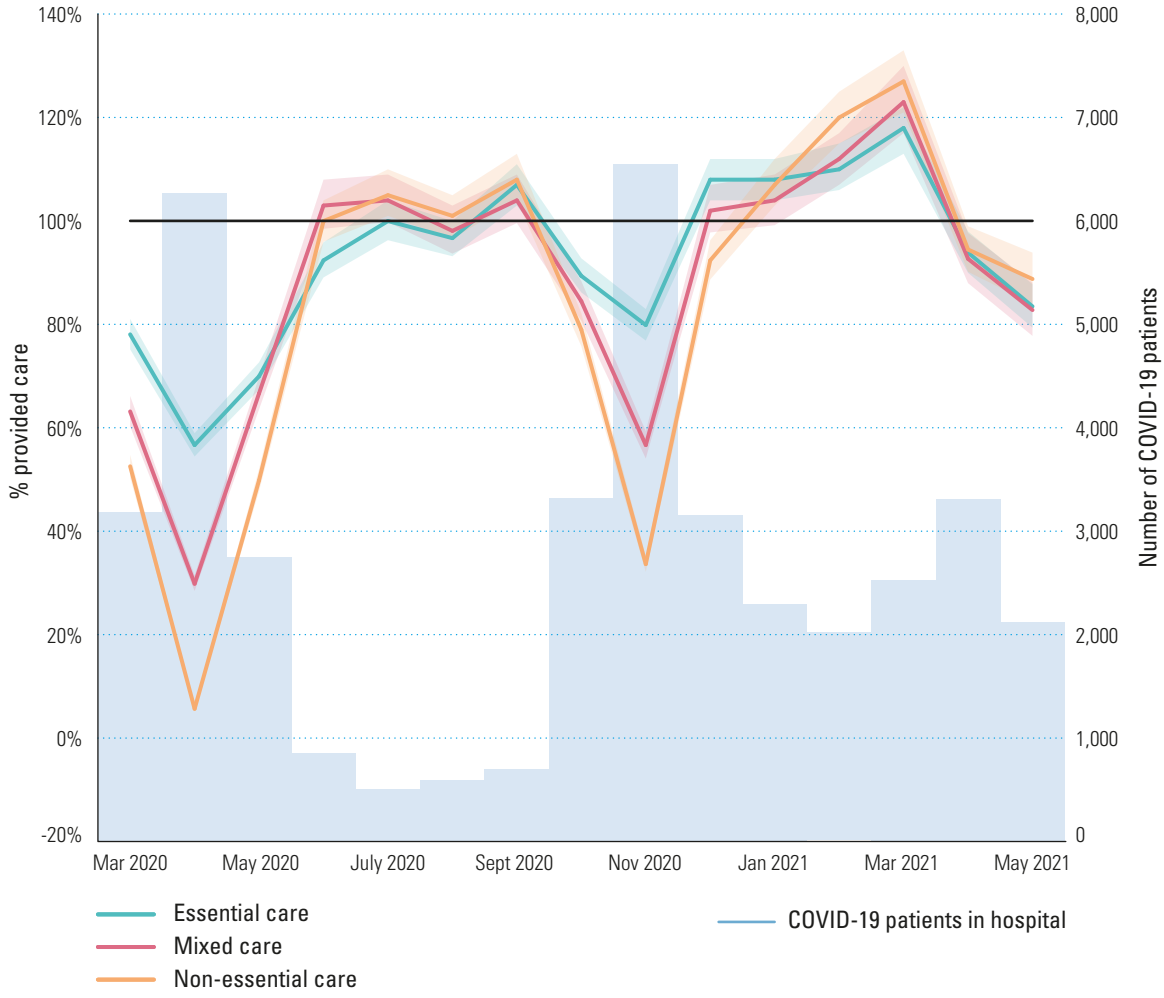
www.vbs-gbs.org

As the second wave gained momentum (autumn 2020), these phases were suspended in reverse order, allowing all necessary and urgent care to continue as before. As such, efforts were made to allow non-essential care to continue as much as possible. It was also necessary to defer non-essential care during the third wave (Spring 2021). In this phase, hospital managers were asked to estimate which care could continue or not, depending on the specific situation.

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.

EVOLUTION OVER TIME OF THE NUMBER OF PROVIDED NON-COVID HEALTHCARE SERVICES [6]

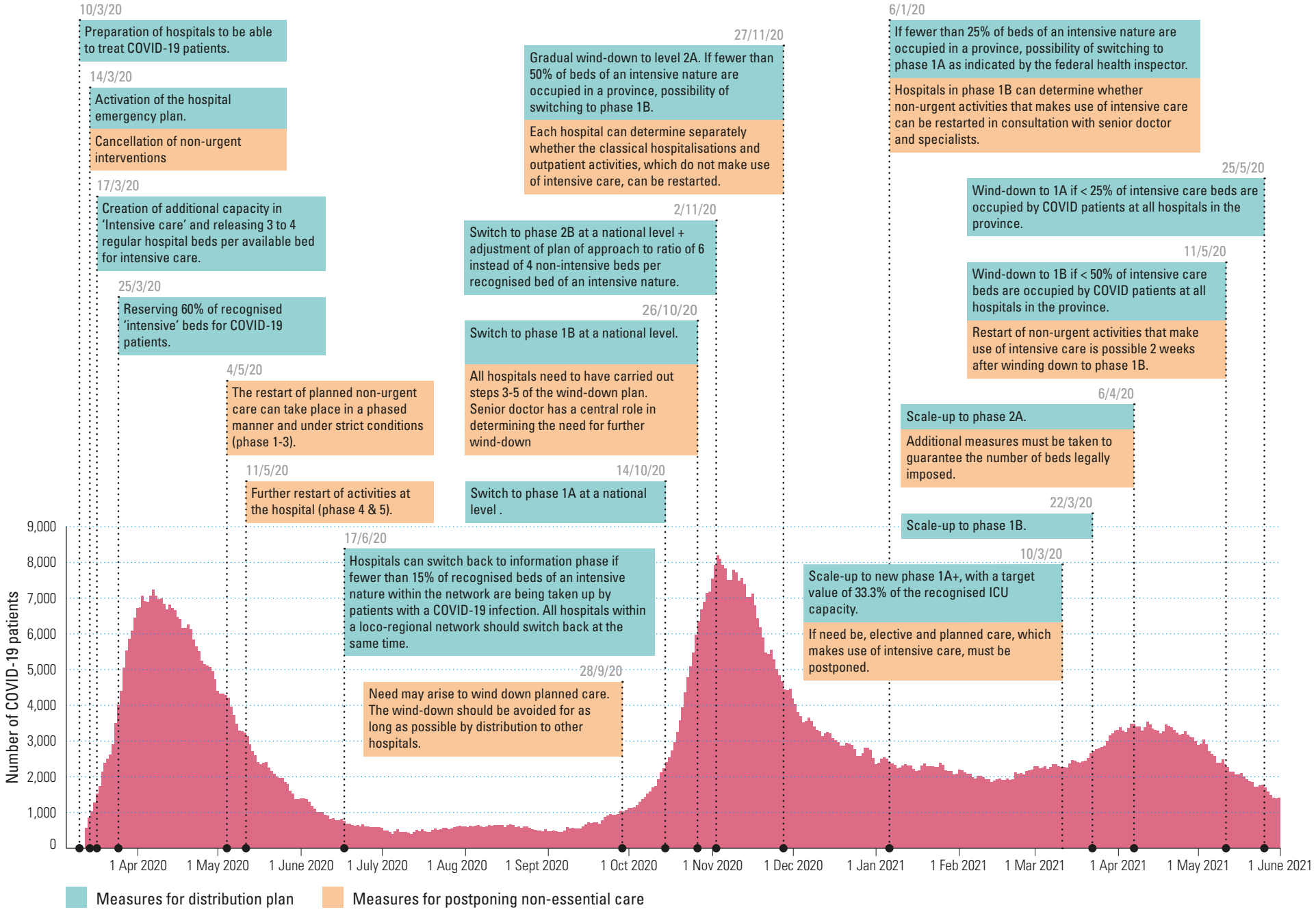


Learn more:

www.riziv.fgov.be

6 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



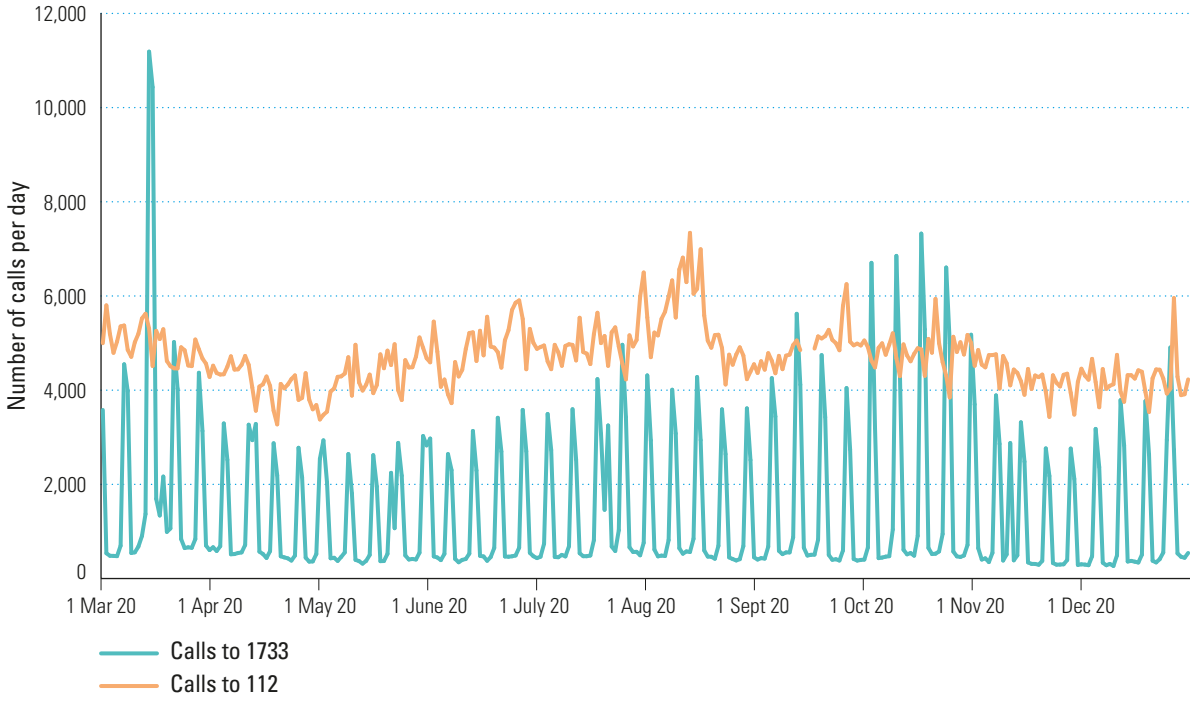
2. Impact of the pandemic on emergency assistance

2.1. Influence of the COVID-19 pandemic on emergency 112 calls and the GP out-of-hours service 1733

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 a GP on out-of-hours service[7],[8].

The number of calls made to the number 1733 reached a record high over the weekend of 14 and 15 March 2020[9],[10]. 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.

CHANGE IN NUMBER OF DAILY CALLS TO 112 AND 1733



Following the weekend of 14 March 2020, it was decided to set up call-forwarding to the 0800 - corona 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 have 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.

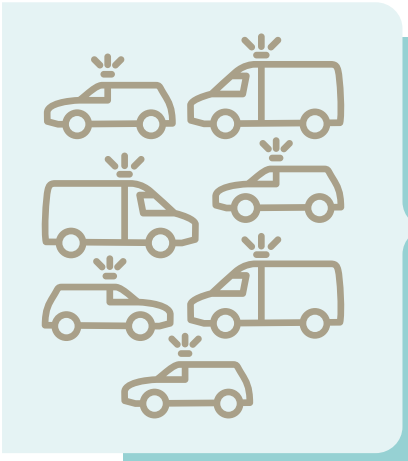
7 More information about how emergency assistance is organised and the telephone numbers 112 and 1733 can be found in the 'Key Data on Emergency, medical and psychosocial assistance'.

8 The number 1733 is not yet fully active throughout the entire Belgian territory.

9 Source: FPS Home Affairs, data from 1/03/2020 to 31/12/2020

10 The weekend effect is clearly visible in the figures for the number of calls to 1733. Logically, there are more calls at the weekend as GPs can be reached directly during the day through the week.

2.2. COVID-19-related interventions with ambulance services

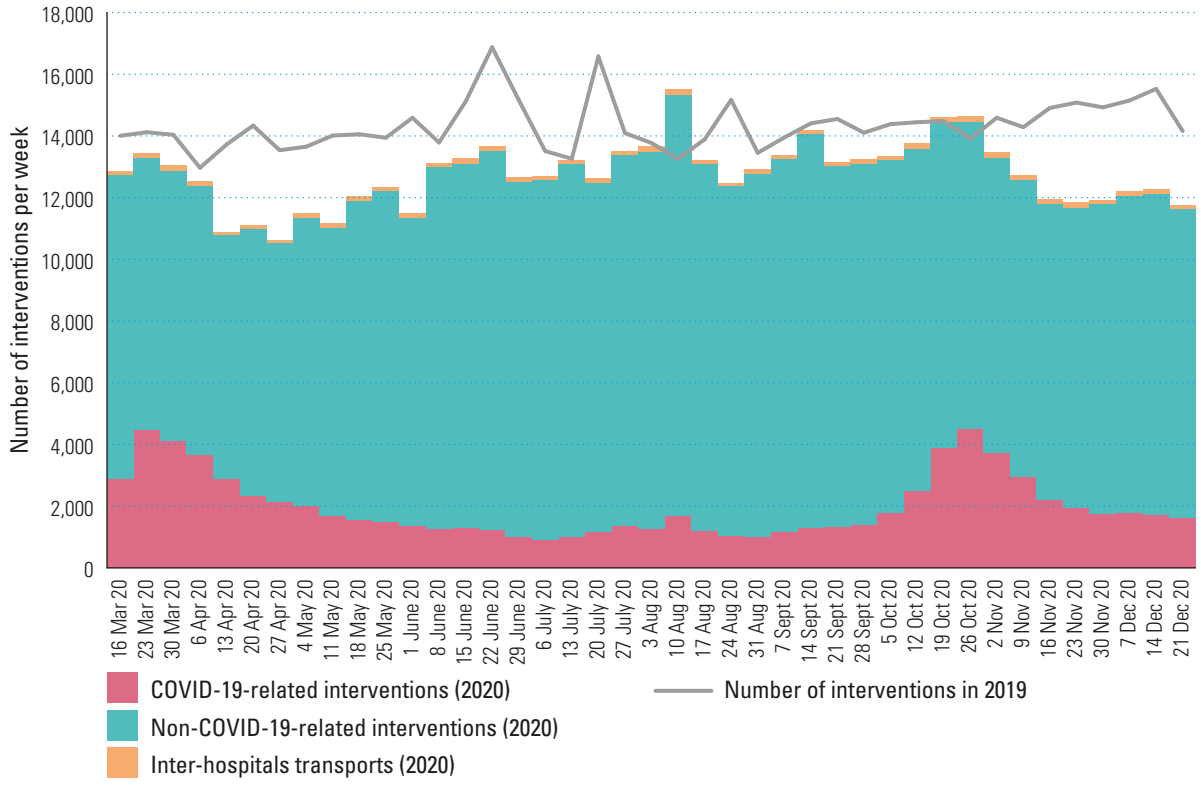


Over the period 16/03/2020 to 27/12/2020, **526,054 primary interventions** in the context of **urgent assistance** were recorded[11].

We can clearly observe a rise in COVID-related interventions during the first and second waves.

Furthermore, we note that the overall number of interventions in the selected period in 2020 is lower than in 2019. The average number of interventions per day was 1,823 and 2,047 interventions respectively. The number of interventions primarily reduced during the peak of the first and second COVID-19 waves. There are several reasons for this: for example, the stricter measures resulted in less traffic, which led to fewer accidents; during the first wave, construction activities were suspended, which led to fewer accidents at work, etc. In addition, the reduction in the number of interventions can be explained by the fact that people postponed their (non-essential) care on the advice of their doctor, in order to reduce the pressure on the health care system or out of fear of going to the hospital.

NUMBER OF (NON-)COVID-19-RELATED INTERVENTIONS BETWEEN 15/03/2020 AND 31/12/2020

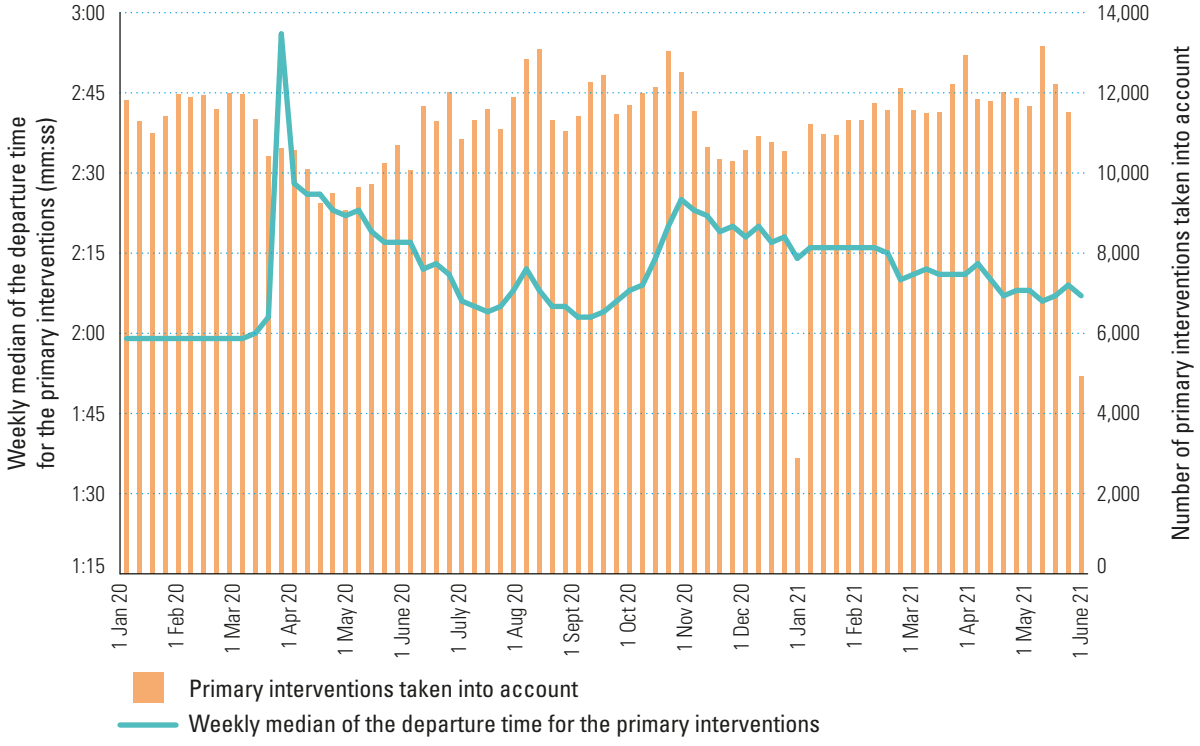


11 Source: FPS Home Affairs and Brussels Capital Service for Fire Fighting and Emergency Medical Assistance

2.3. 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[12]. 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[13].

IMPACT OF COVID-19 ON AMBULANCE DEPARTURE TIMES

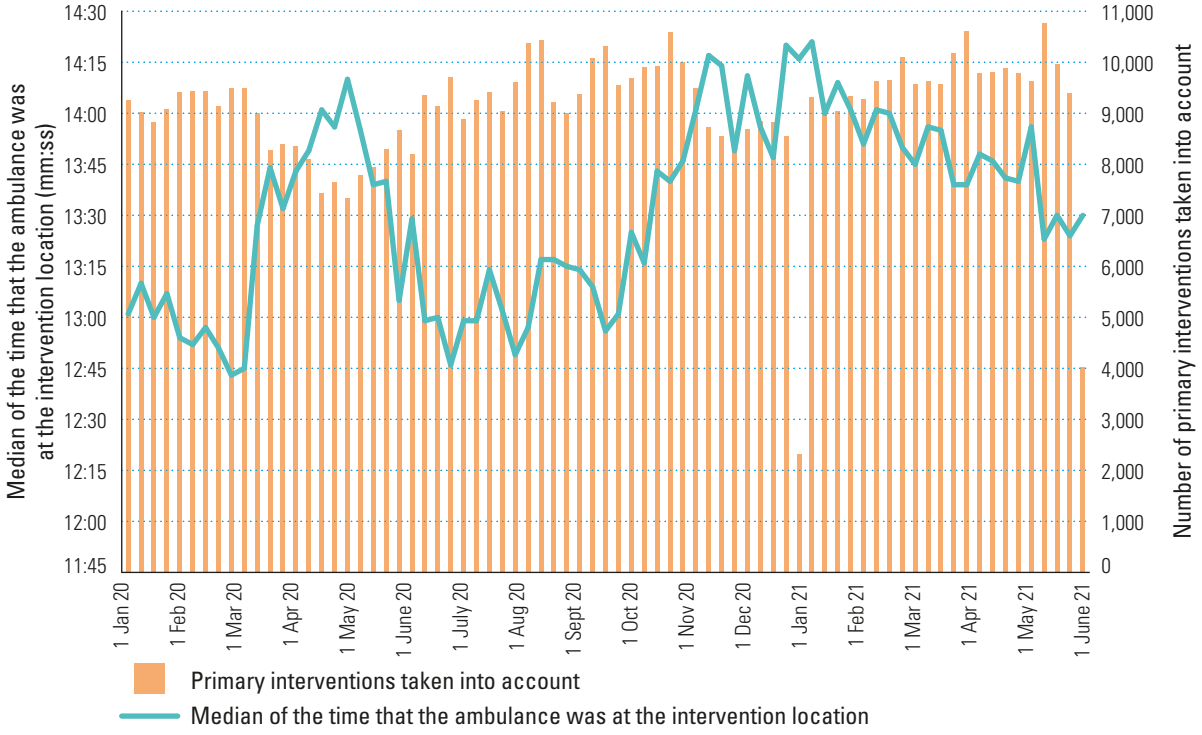


12 Source: AMBUREG, Data and Policy Information Service, FPS HSFCE (7.29% of primary interventions were not taken into account due to missing values)

13 It should be noted that the interventions were taken into account until 31/05/2021. As a result, only a few days (i.e. 28/05/2021 - 31/05/2021) 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 segment. This is because only 2 days were taken into account in this segment (30/12/2020 and 31/12/2020).

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 as the first and second COVID-19 wave gained momentum[14],[15].

IMPACT OF COVID-19 ON THE TIME THAT THE AMBULANCE WAS AT THE INTERVENTION LOCATION



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

2.4. Inter-hospital transport

The distribution plan is an essential part of the efforts to ensure the quality of care and to share the burden of care between hospitals.

For this reason, hospitals were asked to distribute patients as much as possible within their own hospital network or within the province. Hospitals were asked to use their own means of transport as much as possible, which is advantageous in terms of equipment and transport staffing.

The hospitals registered 2,460 transportations of COVID patients to a neighbouring hospital over the period 15/03/2020 up to and including 31/12/2020[16]. If there is no transport available, ambulances can be called via the 112 centre. Over the period 15/03/2020 and 31/12/2020, 6,291 inter-hospital

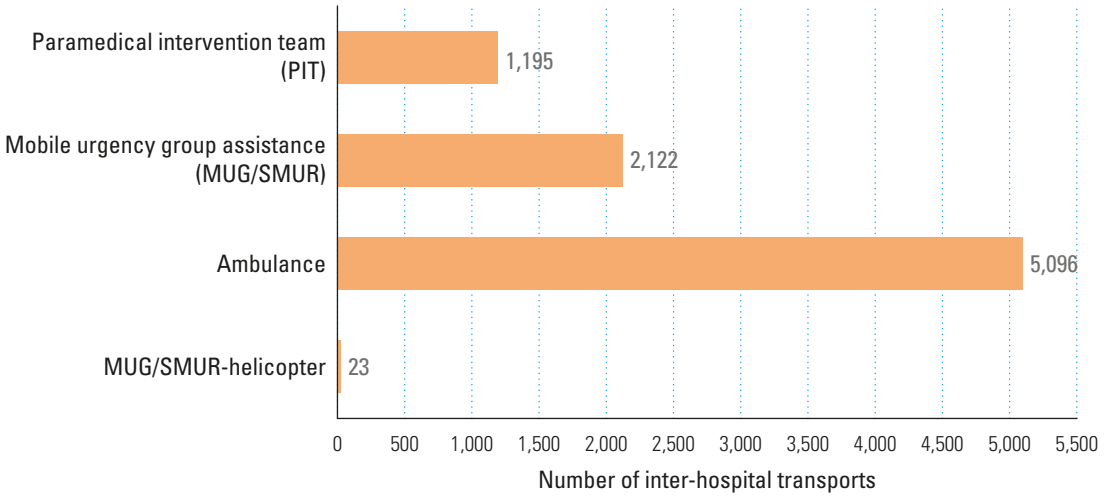
14 Source: AMBUREG, Data and Policy Information Service, FPS HSFCE (24.55% of primary interventions were not taken into account due to missing values)

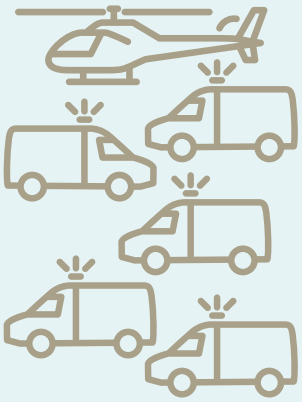
15 It should be noted that the interventions were taken into account until 31/05/2021. As a result, only a few days (i.e. 28/05/2021 - 31/05/2021) were included in the last bar in the graph instead of a full week. It should also be noted that there is a fall in the number of interventions in the 30/12/2020 segment. This is because only 2 days were taken into account in this segment (30/12/2020 and 31/12/2020).

16 Source: Sciensano

transports were recorded with the emergency services centre[17]. This includes both transport of COVID and non-COVID patients To support the teams within the emergency centers, a Patient Evacuation Coordination Centre (PECC) was opened at peak times. This is a unit that was set up within the Ministry of Defence. The PECC looks at which hospitals have available beds and then arranges for transport. No data are available on the number of inter-hospital transports via the PECC.

NUMBER OF INTER-HOSPITAL TRANSPORTS BY TYPE OF RESOURCE VIA THE EMERGENCY CENTRE FROM 15/03/2020 THROUGH 31/12/2020





Over the period 15/03/2020 and 31/12/2020, **6.291 inter-hospital transports** were recorded with the emergency services centre

Furthermore, during the pandemic, 32 patients were transferred from Belgium to Germany and 17 patients from France to Belgium for further treatment[18].

Find out more about the Ministry of Defence's operations in tackling COVID-19 (Dutch and French only):

beldefnews.mil.be

17 Source: FPS Home Affairs; the total number of inter-hospital transports is the sum of the number of interventions with an ambulance and a PIT (paramedical intervention team) function, given that a MUG (Mobile Emergency Group) is always called in as back-up and does not transport the patient.

18 Source: PECC; Figures relate to the period 1/03/2020 to 31/05/2021

FUNDING

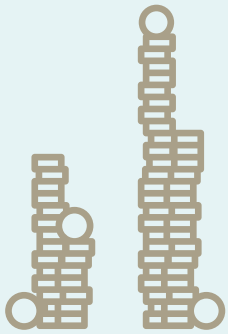
Financial support was provided by the federal government during the COVID-19 pandemic to address specific costs relating to the pandemic in the healthcare sector. Below are some of the initiatives in which the Directorate for Healthcare of the FPS HSFCE was actively involved.

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 result in considerable additional costs.

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

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



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

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 'fixed fee' contributions were intended to provide support for the following matters:

- Exceptional costs due to the COVID-19 pandemic
- Recurring costs
- Additional activities of care providers
- Costs due to the requirement to make a percentage of capacity available for COVID-19 care

The definitive 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

April 2020 **€1 billion**	July en October 2020 **€500 million**	end of 2020	June 2021	2023
• to support costs from March until June 2020 • disbursements to general hospitals	• to support costs from July until December 2020 • disbursements to general and psychiatric hospitals	• provisional settlement 1st advance	• provisional settlement 2nd and 3rd advance	• final settlement

Find out more about the specific rules for the disbursement of funding (Dutch and French only):

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[19]. In addition, as compensation for the COVID efforts made, care staff from the federal sector (including hospitals, district health centres, home nursing services, etc.) are also entitled to consumption vouchers worth €300 per person that can be used in the catering and events sector[20].

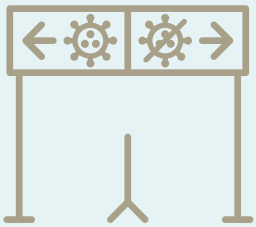
19 Source: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/faq_prime_dencouragement_pour_le_personnel_hospitalier-15_janvier_2021.pdf

20 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 (Dutch and French only):

www.health.belgium.be

2. Funding for triage and testing centres



In 2020,

€ 56,421,000

was set aside by the NIHDI and the FPS HSFCE for **funding triage and testing centres** [21].

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 continued operating costs of the centres[22].

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 was paid out in 2020 by the NIHDI to **fund the transitional care centres** [23].

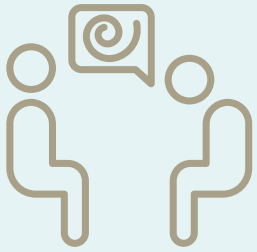
21 Source: NIHDI

22 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

23 Source: NIHDI

4. Funding for psychosocial support

To respond to the increase in psychosocial problems associated with the COVID-19 pandemic, an extension of reimbursement for primary psychological care was approved. An additional budget of €16.7 million will enable children, adolescents and the seniors to consult a primary psychological care provider for the most common psychological problems.



€16.7 million
was released for the
reimbursement of primary psychological care.

Find out more about primary psychological care (Dutch and French only):

General information

Find a primary psychological care provider

Furthermore, actions taken during the pandemic to strengthen mental health care provision included:

- Reimbursement of video consultations by psychiatrists:
- Remote aftercare following admission to a psychiatric hospital[24];
- Possibility of partial hospitalisation at the patient's home[25];
- Awareness-raising among primary health care 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.

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 in the context of this pandemic. The agreement sets out several priority target groups, including children and parents in vulnerable families, young adults, people with existing mental health problems, etc. 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.

24 Find out more about remote aftercare via Remote aftercare by psychiatric hospitals - NIHDI (fgov.be)

25 Find out more about partial hospitalisation at home via COVID-19: psychiatric care: partial hospitalisation at home - NIHDI (fgov.be)

To strengthen the **primary psychological care offering**, €112.5 million has been set aside.

A NIHDI agreement was recently elaborated, in which the practical arrangements and the new convention on reimbursement of psychological care are set out. 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 young people and students, singles and persons working in professions most affected by the pandemic (e.g. health care, hospitality, cultural sector) is most at risk. In order to specifically meet the psychological needs of these most vulnerable groups, the following measures have been taken:

- Psychological care for self-employed people with psychological needs through, inter alia, a free helpline with an annual budget of €55.5 million.
- Outpatient, proactive, psychological (group) interventions for students. €1.5 million was set aside for this.
- Strengthening mobile crisis assistance. €4.7 million was set aside for this.
- Extension of the operations of mobile teams in the mental health networks for the socio-economically vulnerable target group including older people who often do not seek help themselves. An annual amount of €20 million has been earmarked for this purpose.
- An intensification of the residential care capacity for children and young people with serious and complex mental health problems and an extension of the care capacity for accommodating children and young people with mental health problems in non-psychiatric hospital services. Approximately €20 million has been set aside for this purpose.

Find out more about the protocol agreement (Dutch and French only)**:**

www.health.belgium.be

The convention for reimbursement of psychological care started in September 2021 and will last for 3 years. The agreement is a historic step in improving accessibility of psychological care to the public and enables further development of 2 psychological care functions, namely primary psychological care and specialised psychological care within the framework of outpatient mental healthcare.

Find out more about the agreement for the reimbursement of psychological care (Dutch and French only):

www.riziv.fgov.be

Furthermore, additional resources were granted to the Vlaamse Kruis for their cooperation in the management of the corona crisis, including for offering psychosocial support in the COVID-19 call centre intended for the general public.

5. Funding for ambulance services

In the context of tackling the pandemic, 22 ambulance services have added an addendum to their agreement with the FPS HSFCE. 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 corona pandemic.

QUALITY

This chapter discusses some of the initiatives on ensuring quality of care in which the Directorate-General for Healthcare was actively involved.

1. Support for psychosocial well-being

In the context of the Psychosocial Intervention Plan (PSIP)[26], 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 psycho-social 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. As such, the gateway for information on corona 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

26 You can find more information about the Psychosocial intervention plan in the Key data on 'Emergency, medical and psychosocial assistance'.

2. Belgian manual for medical regulation

Calls to 112 and 1733[27] requiring medical intervention are handled by the operators of the 112 centres via the Belgian Manual for Medical Regulation. 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 which resource (MUG, PIT, ambulance, on-call service, house call or own GP[28]) should be sent out or which actions should be recommended in a specific situation.

In the context of the corona crisis, a new protocol was temporarily set up 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 the corona virus.

More information on the Belgian manual for medical regulation (Dutch and French only):

www.health.belgium.be

3. Project 'Digital platform 112 support'

At the start of the COVID-19 pandemic, it was feared that there would be a shortage of regular 112 resources and limited availability of staff.

To avoid this and to guarantee the continuity of the 112 service as much as possible, a digital platform was developed at the initiative of the Belgian professional association of ambulance services (Belgambu) and the FPS HSFCE. The digital platform aims to efficiently respond to a request for support from the emergency centre 112 with support offered by the ambulance services.

During the development of the platform, quality for the patient was always crucial, meaning that only ambulance services and high-quality staff that met specific conditions could be drafted in.

On 2 April 2020, the test phase for the platform was launched in West Flanders. On the basis of this test, the platform was fine-tuned and by the end of June 2020 it was fully operational.

To date, it has not been necessary to activate the platform, as outages have been limited and the need has been met primarily by deploying the resources of the Red Cross. In the future, this platform may be used to organise non-urgent patient transport.

27 1733 is a central telephone number in Belgium to reach an on-call GP in the event of non-urgent medical assistance (see also chapter 'Care activity')

28 See Key data on 'Emergency, medical and psychosocial assistance' for more information on how the different channels work.

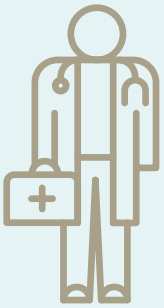
4. Distribution of protective equipment to healthcare professionals working in the outpatient sector

4.1. 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.

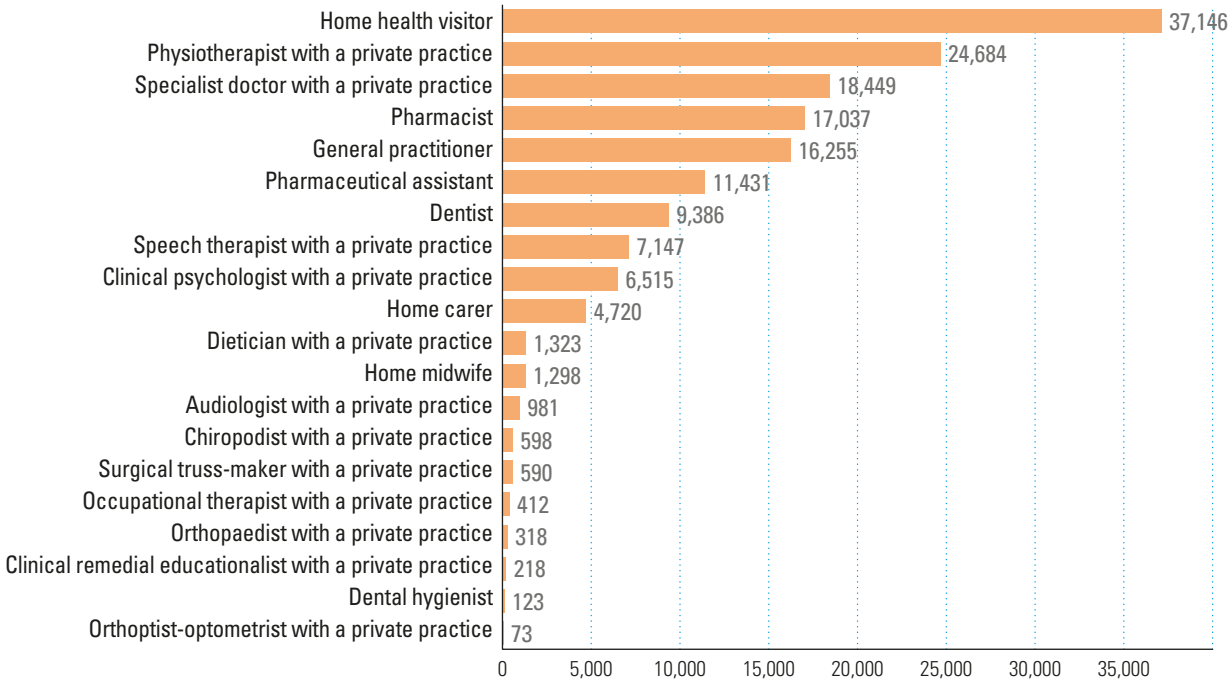
To ensure efficient distribution of this equipment, the first step was to identify these healthcare professionals. The 'Healthcare professions & Occupations' department of the FPS HSFCE compiled a list of healthcare professionals working in the outpatient sector. To this end, various data sources were 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).

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



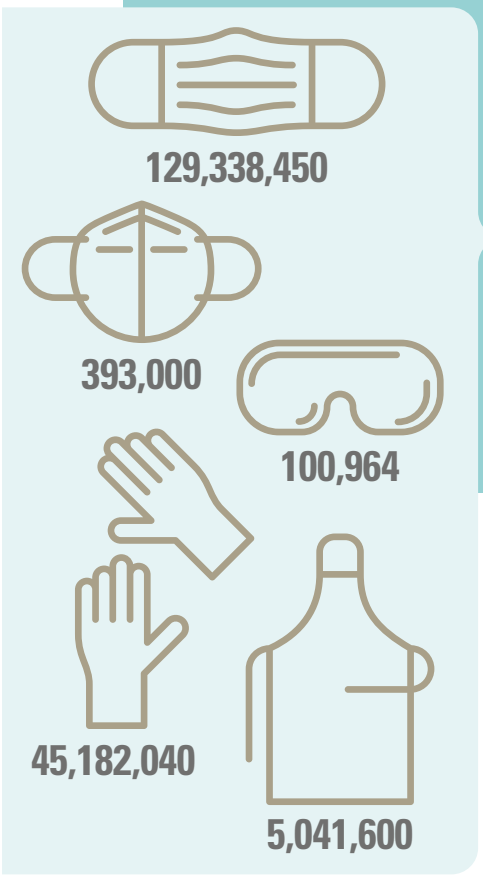
In 2021,
158,704 healthcare professionals were active **in the outpatient sector**.

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



4.2. 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 (Dutch and French only):
www.health.belgium.be

5. Ensuring nursing care

Nurses and other healthcare professionals have been under intense pressure since the beginning of the pandemic. Due to the continued influx of COVID-19 patients, there was a risk that there would be insufficient staff available to administer nursing care.

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. In this way, it is the intention to continue to offer high-quality and safe nursing care as much as possible during the pandemic. It was an exceptional and temporary measure owing to the unique circumstances created by the COVID-19 pandemic. Exercising any of the activities is only possible under strict conditions that are laid down in law[29]: e.g. the supervision of a coordinating nurse is required, training must be followed prior to exercising any activities, etc.

6. Hospital Outbreak Support Teams

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

To this end, the FPS HSFCE launched a call to start up a pilot project 'Hospital Outbreak Support Teams (HOST)'. The objective is to support the existing IPC teams (Infection, Prevention & Control) and AMS teams (Antimicrobial Stewardship) during and after the pandemic. These projects operate according to 2 complementary axes. On the one hand, a locoregional axis that focuses on cooperation between hospitals. On the other hand, a transmural axis that aims to make the expertise of hospitals available to residential institutions and other healthcare professionals.

In the context of the National Action Plan against Antimicrobial Resistance (NAP-AMR), the participating hospital networks will set up a HOST team consisting of experts from the fields of infectious diseases, medical microbiology and hospital hygiene. The team will be tasked with improving the prevention and control of infections. In addition, the HOST team will ensure communication with stakeholders in residential care centres, residential facilities and outpatient care. To this end, they will organise a permanently staffed telephone line and a specific training programme.

Although there are already cooperation agreements between hospitals and residential facilities, the pandemic has highlighted their limitations. Furthermore, the high response rate to the call for pilot projects sufficiently demonstrates the need for better cooperation between the various healthcare actors. There are already 21 Belgian hospital networks involved in the current project.

29 Law of 4/11/2020 on various social measures in response to the COVID-19 pandemic and Law of 6/11/2020 to allow the exercise of nursing activities by persons not legally entitled to do so, in the context of the coronavirus-COVID-19 epidemic.

federal public service
HEALTH, FOOD CHAIN SAFETY
AND ENVIRONMENT