
The essential role of grassroots in health mutuals or how a social economy entity addresses the health crisis

Barbara Sak, Jérôme Schoenmaeckers

CIRIEC Belgio

— Introduction

March 2020, a unique, extreme and unprecedented health crisis broke out in Europe and imposed a lockdown on a large part of Belgian society. Where the federal state, the federated entities and the municipalities had to respond efficiently, quickly and very flexibly to the situation, the established companies and organizations of the health sector, but also the other public companies, were obliged to ensure the continuity and security of essential and vital public services. The idea that Covid-19 impacts society as a whole in equal manner seems false in view of the increased inequalities observed and by the crisis aggravated.

After recalling the challenges faced by different (public or social economy) organizations active in health at the European level, and after presenting some responses of different European countries to face this first wave of Covid-19, a more detailed analysis of the Belgian case will be illustrated by the mutual health insurance company Solidaritis, looking at how it coped with the crisis.

The paper is divided into two sections: the first takes stock of the challenges facing public services while recalling the very idea of public service and the principle of general interest. We also present at the European level which groups have been most at risk in terms of health and some national and/or local responses. After an overview of the European situation, we analyse the Belgian case in more detail in the second part of the article, basing on the interview realized with a key actor, Jean-Pascal Labille, secretary general of the *Union Nationale des Mutualités Socialistes - Solidaritis* (UNMS), a federation of health mutuals in Belgium.

In this paper, we emphasise the essential role of parastatals, on the borderline between the public and social economy. Because of the COVID-19 pandemic, many SSE organisations have had to suspend their activities. This had a very high social cost, given the role that social economy plays in promoting social cohesion and in filling gaps in the provision of social assistance and general interest services. Fortunately, the goods and services provided by mutual health organizations continued to be produced and delivered.

— Challenges faced by public services during the COVID-19 pandemic

Not only health was at stake in the COVID-19 crisis: the mere role of collective public sectors and the importance of essen-

tial services appeared to light, whereas these “essential” workers are not correctly “rewarded” nor recognised and their salaries are too often in the very bottom of the wage-scale.

Theoretical reminder on the concepts of general interest and public service

As soon as life in society appeared, it became obvious that certain functions were easier to fulfil in a group than alone. History shows many examples of groupings of individuals or the pooling of infrastructures to organize collective life. It is as early as ancient Egypt (1400 BC) that we find the origins of the collective economy via mutualist forms: religious associations or stonemasons set up funds to ensure the coverage of expenses for illness or for help in case of accident.

In the Middle Ages, in addition to the clergy who took care of the “poors”, guilds or true mutual aid societies (collective use of the bread oven, of the well...) appeared as early as the 9th century. Other services were provided by these “social economy” grouping, such as protection (of all kinds up to legal assistance) or even mutual aid (in case of calamity, illness, accident, old age, death...). At the outset, they covered only members who had paid their contributions, but which were to have a lasting influence on the notion of collective and then general interest services (Bennet, 1981).

Societies then undergo a more general socialisation of “*functions which, at a given moment, are deemed indispensable when they no longer seem to be able to be satisfied by the family, more or less widely understood, by religious institutions or by private economic activities on the market. As a result of the ability or not of these (family, community, religious or economic) institutions to fulfil these functions, the legal institutions through which the need for socialisation finds a political response arise, i.e. a response that is provided by the state*” (Marcou, 2001, p.367).

When states began to organise themselves, a series of services were very quickly taken over in a centralised, even authoritarian way, to ensure the ‘survival’ of the group. Then, and especially from the 19th century onwards, workers organised themselves to implement “solidarity” - which much later was then, eventually, “taken over” by the states and the European Union, which spoke of ‘social cohesion’. With the development of democratic societies, the public interest may be expressed by the majority opinions emerging from popular consultations and parliamentary decisions. The notion of public or general interest will therefore have very different contents and expressions depending on time and place. Nevertheless,

generally speaking, the public interest can be understood as an interest of societal importance that would be insufficiently met or protected if the government did not interfere. This public interest will then be broken down into public missions implemented in the different fields of public action of a state. However, from one government to another, we will frequently encounter a different interpretation and hierarchy of these public missions, since the pursuit of the public or general interest is not one-dimensional (Fournier, 2015).

As Monnier and Thiry (1997, p. 19, 22-23) explain, the general interest is a "complex societal construct, progressively generated by a multitude of more or less centralised or decentralised initiatives and experiences, based on the respective advantages and disadvantages of public, private and social economy solutions". This societal construct calls for the "definition of objective functions consistent with the conception of the general interest specific to each area of solidarity". And they add that "the search for the general interest frequently leads to indeterminacies linked to the diversity of possible appreciations of the objective itself" and to the "coexistence of diversified organisations which contribute, each in their own way, to the search for the general interest, and whose respective perimeters of solidarity are juxtaposed", or even overlapped. According to these authors, the "mysteries of this socio-economic alchemy of the general interest [are] still far from having been elucidated".

In view of the differences in the form and content of the concept of public or general interest across countries, it is possible to state, in a general way, that an economic activity is assigned tasks and obligations of general interest or public service in one form or another, if private initiative, the market and competition do not guarantee the achievement of the general interest. In this case, the public authorities must intervene (directly or through intermediaries who may be part of the private sector) to ensure that the activity is carried out in a way that is more in line with the general interest or public interest (Thiry, 1996). Based on the contribution of public organizations and enterprises to the achievement of general interest objectives, a narrower classification is indicated for public service missions. This classification follows a "Russian doll" model. In the larger doll of this classification, there are the missions of general interest. The smallest doll is relatively easy to define if we limit it to the minimum service (see below). The difficulty is to identify the intermediate doll or dolls that bring together the public service missions, which are more restricted than those of general interest, but broader than the minimum service (Thiry, 1996).

From an economic perspective, *general interest* missions or obligations can be classified into four main categories:

- 1 "purely allocative objectives which refer to economic efficiency, i.e. efficiency in the allocation of resources [...];
- 2 profitability objectives which can take various forms: profit maximization, cost minimization, respect of the budget balance, achievement of a maximum authorized deficit, capped return on equity;

- 3 objectives concerning redistribution between individuals, or even between regions, which aim above all at the establishment and maintenance of networks and activities throughout the territory, preferential tariffs for certain categories of consumers [...] or so-called tariff equalization systems which generally involve a mechanism of cross-subsidization between profitable and loss-making activities;
- 4 the contribution of companies to the macroeconomic policy of the public authorities (fight against inflation and unemployment, search for economic growth and balance of payments)". (Thiry, 1999, pp. 5-6)

However, other objectives may be assigned, in the name of the general interest, to public or controlled enterprises or to activities of public interest. These include strategic national interests (defence, industrial policy, etc.), heritage or cultural preservation, environmental protection and sustainable development, regional planning, consumer or citizen protection, human capital development, social laboratory to develop well-being, etc. We can thus see there are multitudes of objectives that are not always reconcilable. Then there are the public service missions and obligations, which are only a subset of the missions of general interest. According to Thiry (1999, p. 7), public service missions and obligations cover:

- 1 "overall economic efficiency, which includes taking into account external effects, correcting inefficiencies arising from monopolies, whether natural or not, security of supply, long-term planning and support for R&D efforts;
- 2 missions relating to environmental protection, regional planning, the needs of the nation and the defense of cultural specificity;
- 3 redistributive objectives that can be extended to cover a more general goal of integration".

Two other types of missions and obligations exist. In an even smaller doll, and therefore as a subset of the public service missions, we can list the so-called *universal service* missions and obligations, whose content varies according to the activity concerned. Finally, a last matryoshka concerns the basic or *minimum service* missions.¹ In this period of health crisis, a parallel could be drawn with the continuity of certain infrastructure and public health and safety services considered essential.

Because of COVID-19 pandemic, many organizations have had to suspend their activities. This had a very high social cost, given the role that public and social economy plays in promoting social cohesion and in filling gaps in the provision of social assistance and general interest services.

Health European challenges during COVID-19 pandemic

COVID-19 pandemic impacted the lives of vulnerable population across Europe. According to ESN (2021), three main groups of people have been impacted in Europe from a health perspective: children and families (but particularly women), homeless people (asked to stay "at home" and ap-

¹ It should be stressed here that the minimum service has important implications for the right to strike and a conciliation between the two is necessary to ensure the continuity of certain services

considered essential (surveillance in prisons, public transport, etc.). In this respect, some countries (including Germany, Spain, France, Italy and Portugal) have established rules on the introduction of a

minimum service in the event of a strike in certain essential services.

plying physical distancing rules), adults with disabilities and older people.

Indeed, with the closure of schools, the most vulnerable children could not access support services operating through school such as e.g. food and nutrition services or homework support classes. The most vulnerable children have been the most impacted by untimely school cuts because their parents, many of whom were essential workers in low paid jobs who were still working, could not support them. Further, the pandemic has also seen cases of domestic abuse, specifically against women and children, dramatically increasing, influencing both the physical and mental health of those affected.

Social services authorities operating across Europe reported challenges for people with intellectual disabilities and their families because support structures as day care centres were closed and there was an increased lack of understanding of the rules implemented by the authorities. In the same vein, a major challenge is related to access of information for people with disabilities, such as “the lack of material in sign language or easy to read material when plenty of new information was constantly being produced and could not be provided in hand due to physical distancing rules” (ESN, 2021).

However, the population group most affected by the current COVID-19 pandemic has been older people. A high mortality rate of elderly living in nursing homes has been statistically demonstrated. According to CIHI (2020), the number of COVID-related death in nursing homes during the first wave in spring 2020 represented about 66% of total COVID-related death in Spain, 48% in France, 34% in Germany and only 15% in the Netherlands. Although these numbers do not allow to draw any causal effect, it has been argued that due to the low quality of care and the physical proximity of nursing homes residents, life expectancy was lower than in private homes. This has pointed out that the differences across countries in terms of quality and the institutional features of the nursing homes could be an explaining factor of differential mortality observed in residential housing across European countries (Flawinne et al., 2022). Already at high risk of infection from the virus due to their weaker immune system, older people (living at home or in nursing homes) had to manage an increased need for care and support. Due to the restriction of contacts and the lack of staff, support with everyday tasks at home and personal care in nursing homes have fallen dramatically during the first wave in spring 2020 (ESN, 2021).

In addition to challenges related to the provision of support for specific vulnerable populations, public service workers (whether in the health sector or more broadly) have faced three major challenges (ESN, 2021).

- 1 Firstly, the access to personal protective equipment (PPE) represented one the major challenges for public social services. Even if social services were considered essential by legislations in several European countries, the lack of PPE made the visits at social service centres more complex. A survey organized by the Italian National Council of Social Workers (CNOAS) found that around 30% of social workers had to purchase their protection equipment themselves while 2% declared having worked without PPE, putting at risk professionals but also people using services (ESN, 2021).

- 2 Secondly, the workload increased but not the necessary human resources. Already present before the pandemic, this problematic situation was exacerbated by the fact that some professionals could no longer work. Because they or their family members were symptomatic or at-risk, periods of isolation occurred and the workload was then distributed among the fewer remaining workers. Combined with the fear of infection and the increased childcare responsibilities due to school closures, staff shortages were recurrent.
- 3 Finally, the lack of material resources, such as funding and adequate infrastructure, was an important challenge in order to adapt the way of working. This is as much about emergency financial allowances for different categories of the population (the young, the elderly, people who have lost their jobs because of the pandemic, etc.) as it is about adjusting remote work and setting up remote assistance (and thus investing urgently in a digital infrastructure that was previously very limited).

Health European responses to COVID-19 pandemic

The responses of public and parastatal health services have been multiple in the different European countries. Solutions to collective challenges have been developed while specific support has been put in place for the weakest: the children and their families and older people with or without disabilities. Here are a few examples, beginning with the presentation of some legislative and coordination measures, through investment in technology, emergency assistance, and finally with targeted policies for populations most at risk.

In order to ensure the continuity of certain public services (noticeably social and health related ones), it was crucial to quickly take a series of legislative and policy measures. For instance, in Italy and Spain, both governments have legally recognized the “essential” character of social public services during the crisis. The underlying idea to quickly reallocate professionals was “to where they were needed most, reorganizing work, prioritizing support for people using services based on their degree of needs and vulnerability, providing professionals with PPE to exercise their statutory duties” (ESN, 2021). The coordination between levels of government and between sectors (public, private and third ones) also allowed the continuity of public service, as in Italy where “a civil protection task force coordinated all professionals and volunteers working for emergency services, informing them promptly about decisions taken at the national level, e.g. safety measures and changes in rules” (ESN, 2021).

In different ways, authorities invested in new social and health services technology, enhancing data use and service innovation. Here are three examples from different countries: Spain, Portugal and Belgium.

- 1 The Social Services Observatory of the Regional Ministry of Social Rights and Welfare in Asturias set in place “an early detection and monitoring system to obtain near real-time relevant information on the 240 care homes located in the region” (ESN, 2021). The data collected informed authorities about elements as diverse as capacity of care homes and facilities, impact of the disease among residents and staff, and information about PPE, cleaning and disinfection models.

- 2 In Portugal, the Santa Casa de Misericórdia de Lisboa, responsible for the provision of all social care services in the city, experimented with virtual reality to improve its provision of social services. The objective was to combat loneliness and thus improve mental health.
- 3 Finally, in Ghent, Belgium, the video-conferencing had been put in place to allow visits and face-to-face conversations. A group level support was experimented “using Youtube uploads with messages for wellbeing and physical activities at home and communications with people using social service via sms-apps.” (ESN, 2021).

Finally, several actions have been undertaken in order to support the frontline professionals on the one hand and the vulnerable populations mentioned above on the other: children and their families and people with disabilities and the elderly of our society. Numerous emergency support services for professionals appeared. Let us take the example of Italy where support through the provision of PPE, testing, temporary accommodation (to protect family members from the higher risk of infection to which professionals working in social services might be exposed) had been put in place, next to an essential psychological support to respond to “an increase in burnout among social services professionals during the pandemic” (ESN, 2021). As for helping children and families, a multitude of initiatives have been taken across Europe, such as in region of Campagna in Italy or the canton of Vaud in Switzerland where financial aid but also guarantees in terms of subsidies for health expenses have been provided. In Germany, “parental allowance and support to parents working in essential professions such as healthcare social services or the police, was set up” (ESN, 2021). Finally, for people with disabilities (whether young or old) for whom the situation was most problematic, online help was provided. As day services closed, other solutions allowed reaching out to older people in need of support. For instance, domiciliary care cases were re-assessed to identify those individuals most in need (according to their potential support network). In Lisbon, isolated dependent older people as well as isolated people with disabilities were prioritized. In Barcelona, telecare was reinforced while in several municipalities in the north of Spain or in Wallonia, a program to phone older people was set up and allowed to check their health and emotional status and offer them assistance (ESN, 2021). Public social and health services authorities across Europe have faced very similar challenges in the provision of care to those in need during the COVID-19 emergency, especially during the first wave. Let us now look in more detail at the case of Belgium and how an actor such as a mutual health insurance company reacted in order to allow its members to reduce the health, social and economic shock.

— The case of a Belgian health mutual: Solidaris

Three parts make up this section. First, some details on the Belgian context existing just before COVID-19 that the pandemic exacerbated. To the existing health inequalities, COVID hit Belgium during a political crisis and at a time of labour related disagreements and strike periods in the health sector. The second section presents an essential actor, at the inter-

section of the public and social economy, demonstrating the contribution of the mutual benefit movement to universal social protection. Basing on an interview with the head of the largest mutual insurance company in the Walloon region, the third section presents how Solidaris reacted to the first wave.

Belgian context: a political crisis concomitant with acute problems in the health sector

On March 11, 2020, the World Health Organization (WHO) reclassified the Covid-19 epidemic that had appeared a few months earlier in China as a pandemic. At the same time, Belgium is plunged into a political crisis that appears to be unprecedented in severity since the end of World War II: over one year, there is no majority anymore in the federal government, and for nearly ten months, politicians seek to set up a majority in the House of Representatives resulting from the 26 May 2019 elections (Faniel & Sägerser, 2020). On 3 March 2020, in the House's Committee on Health and Equal Opportunities, the Belgian Federal Minister of Health, Maggie De Block, presented the mechanisms and regular consultations put in place to deal with the detection of new cases of infection. Accompanying the Minister, virologist Steven Van Gucht, director of the established Scientific Committee on Coronavirus, estimated that the worst-case scenario regarding the coronavirus in Belgium would involve the hospitalization of 2,000 to 3,000 people, including 700 in intensive care, figures comparable to those of a “major flu epidemic”.

Things are heating up during the week of 9 March 2020. While we are witnessing a first jump in the purchase of non-perishable foodstuffs (including pasta and rice) and toilet paper by individuals, at the same time, on its side, the National Council of the Physicians sets up procedures, for general practitioners, with respect to phone consultation and issuing medical certificates at a distance.

The particularly complex federal system involves no less than seven health ministers with a minority federal government. Ministers-Presidents of the Regions and Communities were called upon to take, on 12 March 2020, two key measures: the closure of schools for several weeks (a decision that the Flemish government was not initially in favour of), and the closure of restaurants and cafés until at least April 3 (Faniel & Sägerser, 2020). A National Security Council with experts and political leaders now on will have the say. In addition to this political and health crisis, which took turns to take precedence over each other, the situation in the Belgian health sector was already problematic before the start of the pandemic. Indeed, 2019 had seen a rare level of conflict in the healthcare sector (Hirtz & Trionfetti, 2020) with all trade unions uniting and taking actions and strikes. This inter-professional and inter-union movement brought a new dynamic for a convergence of struggles in favour of an improvement in working conditions and an increase in the quality of care. However, during the same year, union negotiations in the public and private sectors remained blocked.

The year 2020 was marked by conflicts announced as early as late 2019 and emphasized by the uncoordinated management of the health crisis due to the Covid-19 pandemic. The labour conflicts in the private health care sector highlighted

structural dysfunctions in the health care model: devaluation of federal health care personnel, understaffing of hospital facilities, deterioration of working conditions for nursing home personnel, and the inability to provide quality care to the elderly. In April 2020, these dysfunctions were at the epicentre of the Covid-19 crisis (Hirtz & Trionfetti, 2020).

These political crises and social movements in the health sector might have been secondary if the situation in terms of inequality of access to care had not worsened over the past 10 years and if a significant part of the population had not been left behind. A study by Baeten & Cès (2020) tends to highlight several problematic situations although they acknowledge that overall general access to health care is relatively good. But disparities between socio-economic groups remain significant and have even increased over the past decade due to the substantial deterioration in the situation of vulnerable groups. The report - commissioned by the Belgian National Institute for Health and Disability Insurance (INAMI/RIZIV) - analyses the characteristics of those who face the biggest hurdles in accessing necessary health care. It also describes the health care services and products for which financial barriers are most important and analyses the main obstacles to access. These are the main results:

- 1 In Belgium, the 20% of people with the lowest incomes are much more likely to have unmet medical care needs than people with higher incomes, due to the cost of such care.²
- 2 Compared to other European countries, the Belgian health care system performs relatively poorly in terms of access to health care for disadvantaged population subgroups.³
- 3 The coverage of hospitalization costs by the compulsory health insurance is very low in Belgium compared to other EU countries. Some patients postpone hospital care in order not to increase their debts.⁴

These difficulties could be relatively easily overcome by different measures, such as administrative simplification, automatic entitlement, desk-personnel helping precarious population or people without digital skills and/or electronic devices, sufficient first-line general practitioners in deprived city districts and in rural areas, etc. But all such services were dismantled year after year to "save money" and lessen public deficits. Decades later, the cost reveals higher than the savings made.

The Belgian mutual health insurance companies: between the public and social economy

In Belgium, the mutual societies are closely involved in the management of compulsory health and disability insurance and act as an interface between the National Institute for Health and Disability Insurance and the citizens. The law thus provides that mutual societies may only obtain or maintain legal personality if they participate in compulsory health care and compensation insurance, on the one hand, and if they set up at least one service whose purpose is to

provide financial assistance for their members and people at their charge. This should be done in respect of the costs resulting from the prevention and treatment of illness and disability or the granting of compensation in the event of incapacity for work, on the other (Law of 6 August 1990, Article 3).

In addition to the services related to compulsory health and disability insurance, the mutual societies also offer a wide range of services, which are part of the free and supplementary insurance; these services vary from one mutual society to another. For example, the mutual society may offer its members hospitalization insurance to cover the costs remaining to be borne by them after the mutual society's legal mandatory intervention. It can also provide financial assistance for numerous and varied types of health services: homeopathy, acupuncture, chiropractic or osteopathy treatment; contraception; obesity treatment; speech therapy; orthodontic treatment; eyeglasses; pedicure; vaccinations (anti-infective or desensitizers), etc. The mutual societies can also offer bonuses and/or assistance in the event of birth or adoption, and provide financial assistance for the costs of sports courses, daycare activities during school vacations or holidays for children. Finally, they organize specific additional services for their members: home nursing care; family assistance; home care for dependent adults and sick children; home delivery of hot meals; loan, purchase or rental of medical equipment; bio-tele vigilance; home palliative care; family planning; transport, etc. To make use of those services, a call-center is very often available 24 hours/day 7/7, and the use of those services is charged at or even below cost price, thanks to the mutual benefit and assistance system.

The definition of the social economy explicitly mentions mutual societies among its components. In Belgium, however, the status of mutual societies is special; in fact, in their function of implementing compulsory health and disability insurance, mutual societies appear almost as parastatals. The almost total integration of mutuals into the social security system has justified the creation of a control and regulation body, the *Office de contrôle des mutualités et des unions nationales de mutualités* (OCM), to which mutuals are subject. Some analysts therefore consider that mutuals do not fully meet the characteristic of management autonomy and that they do not therefore belong to the social economy. Thus, the accountants of the National Bank of Belgium include mutuals in the public administration sector, at least for the part of their activities relating to compulsory health and disability insurance. Nevertheless, according to researchers from CES or CIRIEC,⁵ there are three arguments in favor of including mutuals in the "third sector" or social economy. The first argument concerns their activities: in addition to the implementation of compulsory health and disability insurance, mutuals also develop, in a more autonomous way, complementary insurance and very diverse and numerous social services, particularly in home care, which fall within the scope of the social economy. The second argument is historical: although

² For example, the sharp increase in the rate of unmet health care needs among the lowest income group is of particular concern: from 4.1% in 2011, it rose to 6.7% in 2017, and with COVID and without additional intervention by mutual health insurance companies, this rate could have increased (Baeten & Cès, 2020).

³ These people have not been able to pay their compulsory social security contributions, in particular self-employed people. This risk was aggravated by the pandemic. Other people are entitled to coverage but do not take the necessary administrative steps (e.g. due to lack of information, language barriers, or mental health problems). The obligation

to pay advances (with the fee-for-service system) is a major obstacle also for ambulatory care.

⁴ As a result, some hospitals and doctors are refusing to treat patients who are in default.

⁵ CES= Centre for Social Economy and CIRIEC = International Centre of Research and Information on the Public, Social and Cooperative Economy.

mutuals have now become quasi-parastatal institutions, they were undoubtedly originally social economy organizations. Finally, from a legal point of view, they are still separate entities from the State. Mutuals are therefore considered, relatively consensually, as a component of the social economy.

Eight major benefits of health mutuals were presented, recalled by ISSA (2013). These are listed below:

- 1 mutual societies reduce the financial barrier;
- 2 they focus on meeting the needs of their members;
- 3 they make health care more accessible and manageable for their patients;
- 4 they promote social ties;
- 5 they cover all segments of the population, including at-risk or disadvantaged populations;
- 6 they are crisis-resistant;
- 7 they act in the long term;
- 8 they are not only "payers" but also "actors" and promote patient information and education.

The next section presents how a large Belgian health mutual society, Solidararis, helped mitigate the health crisis for its members. This section notably features some statements by Jean-Pascal Labille, secretary general of the *Union Nationale des Mutualités Socialistes - Solidararis* (UNMS).

How does the social economy entity Solidararis respond?

In managing the health crisis, Solidararis has been on all fronts: it has expressed itself as a social and political actor in the media, adapted its products and developed new services in order to respond to the social and economic consequences of this crisis. Further, Solidararis managed to avoid its services from being shut down. By working with their network of associations and frontline workers to maintain access to quality care, and with trade unions to value the work of all care providers during the crisis, Solidararis has shown *"extraordinary flexibility and agility in improving its institutional efficiency, giving further credibility to the indispensable place that our mutual society occupies in our health system, a technical player with high added value in the management of insurance, a political player in its defense of the social rights of all citizens"*. The countless hours and flexible implication of first-line workers (involved and employed by a social economy entity) enabled the mutuals, knowing the individual needs of their members, to act as "intermediary" between the state and the citizens.

Four axes have been identified in the Solidararis response to the health situation: the inter-mutual response within the framework of tracing, the reinforcement of the presence of the mutual insurance company with its affiliates, the provision of responses to psychological emergencies and to the deterioration of mental health, and finally the assurance of price/fare security. Each axis is detailed in the following subsections. Solidararis' responses presented took place in the first wave of the epidemic in spring 2020, but the majority of them are still relevant today.

The inter-mutual response within the framework of tracing

From the start of the health crisis and in the three regions of the country, the mutual insurance companies have been

involved as field operators in the follow-up of contacts in order to break the transmission chains of the virus. In this respect, they had immediately set follow-up procedures together with important guidelines, especially in terms of privacy protection.

Given the importance and urgency of the task and at the request of the authorities, all the Belgian health insurance companies had organized themselves into a consortium with call center companies - including those in the social economy - and interim agencies to set up, in a matter of weeks, a contact tracking system supported by an IT architecture developed by Sciensano (the national institute of public health) and SMALS (the organization in charge of IT for the federal administrations).

Information about index patients (COVID-19 +) arrived electronically on a platform. Call center agents who used scripts to ask them the questions necessary to compile a list of their contacts called these people. These contacts were then called in order to communicate the instructions to be respected and, if necessary, a code to carry out a PCR test and a certificate of quarantine (official document) was sent to them.

The "communities" such as nursing homes, schools, occupational medicine companies were also contacted if necessary so that they could take measures at their level. If the call center was unable to reach the person within 48 hours or if the person refused to cooperate, a mutualist agent was sent to the person's home. This personal and physical contact revealed extremely important to explain and convince.

As a proximity actor, the mutualities have been particularly committed to providing field agents in the teams. The arrangements are flexible and evolve according to the epidemic. The system started with 400 agents in call centers and 150 agents available for field visits. This number was increased in July 2020 by 90 FTE "call center agents" and 8 FTE "field agents". Workloads are still being closely monitored. The processing of information concerning people who have stayed abroad or foreigners who have had contact with Belgians with COVID-19 is also managed by the consortia (e.g. processing of Early Warning and Response System of the European Union (EWRS) and paper PLFs (Passenger located forms).

The reinforcement of the presence of the mutual insurance company with its affiliates

The aftermath of the health crisis is reflected in an increase in precarious situations, on the one hand, and a consequent increase in requests for assistance from social and health services, on the other.

Two groups of people/families are particularly concerned by the social emergency:

- 1 people who are vulnerable or in a precarious situation and who were already vulnerable or in a precarious situation well before the Covid-19 crisis;
- 2 people (working or not) impacted by the health crisis situation, weakened by the loss of income, and/or by the loss or closing of their usual contact point/person.

During the first wave of the Covid-19 crisis, the Solidaris social and health network, in this case its home help and care services, really played their role in helping and supporting the most vulnerable people in their living environments. In this sense, according to Jean-Pascal Labille: *"our network has fully assumed its role as an essential link in the chain of assistance and care as the first line, thus avoiding an explosion in the number of hospitalizations and saturation of this network"*. Indeed, despite the lack of PPE (Personal Protective Equipment) and the anxiety-inducing context, the vast majority of workers in the field (family assistants, nurses, housekeepers, childcare workers, bio-telemonitoring workers, meal delivery workers, aid and care coordinators....) had continued to go to the homes of their beneficiaries, thus ensuring that this often fragile public (physically, medically and socially....) did not sink into total isolation and a certain form of physical, psychological and social decline. Moreover, particular attention was given to elderly persons living alone, to make sure that care was taken of them.

The provision of responses to psychological emergencies and to the deterioration of mental health

The effects of the COVID-19 sanitary crisis on wellbeing are immense, and to the sanitary crisis and to the confinement that accompanied it, follows now a new economic crisis, marked late 2021-early 2022 by a record inflation due to the increase of the energy prices. Different studies (Panchal et al., 2021; WHO, 2020) highlight the fact that the society has not only to face the addition of the psychological effects of these two crises but rather their multiplication. The threat of an individual and collective post-traumatic shock (at the crossroads of the medical, psychological and social) is to be expected, all the more so as burnout and stress at work had already exploded in recent years, considerably impacting the number of people unable to work, which has increased by 70% in ten years in Belgium (according to ONSS⁶ statistics that point to long-term absences from work due to mental causes).

Solidaris was quickly concerned about the psychological traumas generated by the various confinements and de-confinements. Certain professions and groups are particularly affected. The COVID-19 crisis, its economic and social impact, had noticeably effects on the mental health of self-employed people who had to close their establishment, store, business, on which often rests their entire source of income of a family. In order to avoid situations of ultimate despair and suicidal risk, and to respond to the growing needs of self-employed people in distress, the Reference Center for Suicide Prevention has decided to develop the APESA Wallonia project (Psychological Help for Entrepreneurs in Aggravated Suffering) supported by a social economy non-profit entity *"un Pass dans l'impasse"* and by the Walloon public authorities. Together, they set up a new free helpline to support self-employed people in distress. The setting up of a network of sentinels in suicide prevention for self-employed people in distress: members of the Business Courts, accountants, trade unions, banks, etc. were trained to identify self-employed people in distress and who needed help. Their role was to launch an alert so that a psychologist

could contact the self-employed person in distress in order to provide psychological support.

The assurance of price/fare security

Finally, it is clear that not all people are equal in the face of coronavirus. It is worth remembering that the less educated, persons with migration backgrounds, socioeconomically disadvantaged are overrepresented among the chronic disease groups. Solidaris has paid particular attention to patient price/fare security so that "health-related deferral of care" is not coupled with "financial-related deferral of care".

To this end, rules have been put in place to make interventions more flexible: extending the age limit for orthodontic, eyewear and speech therapy interventions. In connection with point 3.2.3, psychological consultations were extended to the entire population and the number of annual services was increased from 8 to 12. Other measures to facilitate reimbursement have been taken in the pre- and post-hospitalization phase. Finally, Solidaris covered certain dental care services for insured persons stranded abroad, even though the coverage was limited to Belgium.

Finally, the demands of Solidaris to stop charging patients for supplements (costs of individual protective equipment and practice disinfection costs) have been heeded. Moreover, following joint actions with a trade union, the incapacity benefits have been temporarily increased for low and middle incomes, with a guaranteed minimum of 61.22 € per day, in order to be in line with the temporary unemployment benefits increased due to the coronavirus.

Jean-Pascal Labille concluded by reminding that *"Solidaris is more mobilized than ever to defend these precious gains and to reinforce our collective fight for quality health care, accessible to all"*.

— Conclusion

Although all spheres of the population were affected, the health crisis hit the most vulnerable European populations hardest. Across Europe, there are many examples of public services and social economy organizations working together to mitigate the effects of the pandemic. In Belgium in particular, we focused on the role of a mutual health insurance company as an interface for the public authorities. It is important to remember that Solidaris is part of a Belgian network of mutuals not only via the agencies/offices, but above all via the numerous non-profit associative relays making up the "network" of services to members. This network is based on a real win/win and cost-effective partnership between the public authorities (from the federal to the local level) and the basic public/social services provided by the "mutualist construct". This network made the system work, as the mutuals had the knowledge and the relay to their members.⁷ This also illustrates the capacity of these mutuals (and trade unions)

⁶ The National Social Security Office.

⁷ Let us point out that 2% of Belgians do not have

a mutual insurance. The latest figures from the RIZIV show that 200,000 Belgians are without a

mutual insurance company. More than 100,000 of them are not in order to pay their contributions for

to federate and mobilize around a necessary "solidarity". The health crisis has also highlighted the "social" and "popular education" role of mutuals. Finally, mutual insurance companies seem to be there for everyone, at all stages of life, to accompany and offer services that "make it easier" to deal with life's hazards. It is certainly an insurance system, but mutualized in many senses of the term.

However, if we think about it and look at what has happened outside of this health framework during this pandemic, unfair profit sharing occurred between those who benefitted economically from the pandemic (such as the supermarkets

or the platform economy) and their employees. This injustice has widened inequalities because wages have not increased. This reminds us of the political divide that could emerge in many member states post-Covid as the non-recognition of the role of essential workers is not limited to Belgium. This illustrates, on the one hand, the paramount role that non-profit organizations and enterprises will have to play and, on the other hand, the primordial intervention of the state (whether through regulation or the provision of public goods and services) in the construction of the post-Covid world.

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Although this is essential to obtain reimbursement for health care. There is a public service alternative

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