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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN BELGIUM

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Abstract – This report describes the organisation of the Belgian long-term care system. It can be characterised as a mixed system, with extensive public care provision and the substantial support of informal care provided mainly within the family. While the current volume and quality of services appears to be adequate, the future increase in the number of dependent elderly persons over the next two decades as a result of demographic ageing can be expected to become a serious challenge, in terms of both the required formal and informal care capacity and financing.

JEL Classification – H51, H55, I18

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Contents

1.	The Belgian long-term care system	1
1.1	Overview of the system (including the philosophy of the system).....	1
1.2	Assessment of needs	2
1.3	Available LTC services	2
1.4	Management and organisation (role of the different actors/stakeholders).....	4
1.5	Integration of LTC.....	4
2.	Funding	5
3.	Demand and supply of LTC.....	6
3.1	The need for LTC (including demographic characteristics)	6
3.2	The role of informal and formal care in the LTC system (including the role of cash benefits)	7
3.3	Demand and supply of informal care.....	9
3.4	Demand and supply of formal care.....	11
4.	LTC policy	17
4.1	Policy goals.....	17
4.2	Integration policy.....	17
4.3	Recent reforms and the current policy debate	18
4.4	Critical appraisal of the LTC system.....	19
	References and relevant website links	20

List of Figures

Figure 1.	Formal and informal care use in Europe (SHARE, 2004)	8
Figure 2.	Preferences of care setting and provision in Europe (2007)	9
Figure 3.	Expectations about the appropriateness of care provision in Europe (2007).....	15
Figure 4.	Quality assessment of home care provision in Europe (2007).....	16
Figure 5.	Quality assessment of nursing home care provision in Europe (2007).....	16

List of Tables

Table 1.	Long-term care expenditures by care setting and funding source (2006, M€) ¹	6
Table 2.	Current and projected number of elderly persons (aged 50+) in need of LTC.....	7
Table 3.	Probability of giving informal care by age, gender and occupational status (%)	10
Table 4.	Recent developments in the supply of semi-residential care facilities in Flanders.....	11
Table 5.	A breakdown of residential patients by care level (selected years).	12
Table 6.	A breakdown of home nursing care patients by care level (selected years).	13
Table 7.	A summary of LTC needs, use and resources in Belgium in 2006.....	14

The Long-term Care System for the Elderly in Belgium

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Peter Willemé*

1. The Belgian long-term care system

1.1. Overview of the system (including the philosophy of the system)

Long-term care (LTC) in Belgium consists of a wide range of services organised at the federal, regional and municipal levels, and is related to health and social service provision.¹ The bulk of LTC services is provided as part of the public, compulsory health-insurance system at the federal level (Federal Compulsory Health Insurance Law of 14 July 1994), which is financed by social security contributions and general taxes. As public health insurance practically covers the entire population, LTC coverage is also nearly universal (especially since ‘small risk’ insurance has recently been extended to cover self-employed persons, who were not covered for these risks by the public, compulsory health-insurance scheme prior to 2008). However, given that long-term care services provided by the health insurance system only cover nursing care (as well as paramedical and rehabilitation care) for dependent persons (in both residential and home care), a broad spectrum of services has been organised and is provided at the regional and local levels. Indeed, while there is no specific long-term care legislation at the federal level, the regional governments have issued decrees that regulate a wide range of issues related to LTC services: the certification of facilities such as nursing homes and day-care centres, integration and coordination of services at the local level and quality monitoring systems. One community (the Flemish) has set up a separate scheme for long-term care insurance, partly financed by a general contribution from the adult population and aimed at alleviating the burden of non-medical long-term care expenses by means of a cash benefit. Generally speaking, the Belgian LTC system can be characterised as a mixed system, with extensive, publicly financed formal care services that are complemented by significant informal care provided mainly within the family.

Belgian long-term care policy aims at helping, supporting and nursing dependent (elderly) persons. As a rule, the objective is to support dependent elderly persons in their own natural environment for as long as possible. If limitations in activities of daily living (ADL) become too

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¹ The federal structure of the Belgian state results in a rather complicated division of power between the federal and the regional authorities. At the sub-national level there is a territorial division (the Flemish, Walloon and Brussels Capital Regions) and a ‘cultural’ one (the Flemish, French and German-speaking Communities, plus commissions responsible for the Flemish, French and bilingual institutions in the Brussels Capital Region). While the organisation of the social security system (of which public health insurance is part) is a federal responsibility, the Flemish, French and German-speaking Communities are responsible for ‘people-related matters’, including some that affect health and long-term care. As a result, most non-medical aspects of care for the elderly are Community responsibilities. The Flemish and German-speaking Communities assume their responsibilities themselves, while the French-speaking Community has devolved its responsibility to the Walloon Region for matters relevant to the Walloon territory (but it remains responsible for the Brussels Capital Region). Despite these institutional complications, we use the generic term ‘regional’ in the rest of the text to designate the sub-national level of authority.

severe and adequate support at home (both informal and professional) is unavailable or insufficient, the dependent person should have access to suitable and affordable residential care facilities. To achieve these broad policy goals, a range of residential and home-based LTC services has been developed. In the residential sector, homes for the elderly and nursing homes provide care and living facilities for dependent elderly persons. Additionally, no- or low-care elderly persons (and moderately and severely disabled persons having adequate informal care) can stay in ‘service flats’ and similar accommodation, which combine individual living arrangements with collective facilities (meals, home help and so forth). Day-care and short-stay centres provide care services for elderly dependent persons who still live at home but (temporarily) lack adequate informal care or whose caregivers need respite time. Finally, home care and home nursing care services support elderly persons who need help with (instrumental) activities of daily living (IADL).

1.2. Assessment of needs

The patient generally initiates a request for LTC services by contacting a medical doctor (usually a GP), a qualified nurse or a social worker (depending on the type of care sought), who assesses the severity of ADL or IADL limitations using an official scale. It follows that the assessment is carried out by a health practitioner who may be one of the subsequent service providers. There is no independent entity that assesses the patient’s condition prior to the provision of LTC services, but ex-post random evaluations of the dependency category are routinely carried out (in the residential sector, for instance, the dependency category can be changed after an evaluation by a ‘college of advisory physicians’, working under the auspices of the National Health Insurance Institute).

Different scales are used to assess the dependence category of the patient in different care settings, but they are all extensions of the well-known Katz scale. In residential care and home nursing care, the patient’s score determines the care level that he or she is entitled to receive, or more precisely, that will be covered by the public health insurance scheme. Home care needs are assessed by a social worker using an extended scale, which includes IADL limitations. The assessment determines the amount of care financed by the regional authority to which the patient is entitled. The level of public financing is means-tested and based on household income.

In Flanders, the BEL scale adds ‘domestic’ (IADL), ‘social’ and ‘mental’ criteria to the usual six items of ‘physical’ ADL limitations. Patients with a score of 35 points or more are entitled to receive a fixed monthly cash benefit. Notably, a formal assessment is not required for patients who can prove their dependency by alternative means (for example proof of residence in a nursing home). Another cash benefit (the allowance for assistance to elderly persons), financed and organised at the federal level, uses a separate scale with ADL and IADL items and a medical assessment by a doctor of the Federal Social Security Service. This allowance is means-tested.

Given the division of responsibilities among the central, regional and local authorities, different needs are assessed with different instruments. To reduce overlap and inefficiency, ‘integrated home care services’ are being established, which coordinate the efforts of multidisciplinary teams.

1.3. Available LTC services

Long-term care in Belgium, as in any other country, consists of a mix of formal and informal care. The latter is provided mainly by relatives, especially spouses and children. It is estimated that almost 10% of persons aged 15 or over provide informal care (Census, 2001). The care burden is distributed unevenly over gender and age groups, with women between 45 and 64

years old having the highest probability of providing care. Intensive care (more than 2 hours per day on average) is more likely to be provided by unemployed and low-skilled persons. Very intensive care (more than 4 hours per day on average) is concentrated in the age groups 65-74 and 75+, consisting predominantly of care between elderly partners (Deboosere et al., 2006).

Formal long-term care services consist of benefits in cash and in kind, which are discussed in turn below.

There are two major cash benefits targeted at alleviating the financial burden of non-medical expenses incurred by long-term care recipients. At the federal level there is an allowance for assistance to elderly persons, which is part of several allowances for the handicapped. It is a monthly allowance, allocated to elderly persons (aged 65 years or older) who score a minimum of 7 points on a scale that includes ADL and IADL limitation items as well as a medical assessment. The level of the cash benefit also depends on the financial situation of the applicant, which takes into account current income, financial assets and non-financial assets. At the regional level, Flanders has set up a separate long-term care insurance scheme that pays a monthly allowance to patients who score at least 35 points on the BEL scale or who can prove their need for care by other means (as discussed above in section 1.2). The monthly allowance, which is used to distinguish between home care and residential care recipients, is not means-tested.² There is no age limit, but eligibility is restricted to Flemish residents and residents of the Brussels Capital Region (with some restrictions).

Long-term care benefits in kind come in a great variety, and are described here according to the care setting. In residential care, nursing care is provided to (mainly elderly) patients with low to moderate limitations in homes for the elderly, and to patients with moderate to severe limitations (including dementia) in nursing homes. Eligibility depends on the severity and number of limitations, and is evaluated using the familiar six ADL items of physical limitations augmented with a mental criterion (disorientation in time or space). Transmural care, in a semi-residential care setting, is provided in day-care centres and short-stay care centres. These facilities provide nursing care to ADL-restricted persons who still live in their own homes, but who have limited or temporarily restricted access to informal care. Short-stay centres in particular provide residential LTC services to patients for a limited time period to temporarily alleviate the burden of informal caregivers. Day-care centres do not provide sleeping accommodation. Both types of transmural care facilities are available for patients with moderate to severe ADL or mental limitations who continue to live at home with the help of informal caregivers. The same criteria are used as in residential care. Home nursing care is available for persons with mild to severe ADL limitations, irrespective of their age, their income and the availability of informal care. The eligibility for and intensity of care (and the corresponding level of financial intervention by the federal health insurance system) is determined using the same criteria as in residential care. Home care services include help with IADLs and personal care, such as cleaning and other domestic tasks. Eligibility depends on the severity of the patient's limitations, which also determines the number of hours of care provided. Care recipients pay an hourly fee, which depends on their financial situation and the severity of their needs.

² The Flemish Care Insurance was established in October 2001 and was initially limited to home care. It was extended in July 2002 to residential patients. The allowance was gradually increased to €125 for residential patients and €95 for home-care recipients. Both groups of beneficiaries currently receive €130 per month.

1.4. Management and organisation (role of the different actors/stakeholders)

The organisation of long-term care services is divided among the federal, regional and local levels according to the division of responsibilities in Belgian constitutional law. As a general rule, health care is a federal responsibility, and personal care a regional one. As a result, long-term care services that require the intervention of medical doctors and paramedical and nursing staff are in principal organised at the federal level. They are part of the mandatory public health insurance system and financed by contributions and taxes. The main actors are the federal parliament (issuing the main laws governing the system), the ministries of health and social affairs, the National Institute for Health and Disability Insurance (NIHDI, the *Rijksdienst voor Ziekte- en Invaliditeitsverzekering, RIZIV/INAMI*), and the sickness funds (which serve as intermediaries between the administration, the providers and the patients). The federal ministries of health and social affairs, together with the NIHDI, are responsible for the overall LTC budget (essentially residential care and home nursing care, which are part of the public health insurance system), overall capacity planning (mainly the number of beds in nursing homes), fees and levels of public intervention (through negotiations with the providers' organisations). Responsibility for the certification, monitoring and quality control of residential care services is divided between the federal and regional levels. A portion of the budget corresponding to the maximum number of beds set at the federal level is allocated to the regions, which can decide on the allocation to services in different semi-residential and residential settings or those supporting home care (see section 4.2). Home care services are regulated at the regional level and organised locally.

Residential care services are provided by local Public Centres for Social Welfare (abbreviated as OCMW in Dutch and CPAS in French) and by both non-profit and for-profit private organisations. Home nursing care is provided by qualified nurses, either self-employed or employed by private non-profit organisations or Public Centres for Social Welfare. Both non-profit private providers and Public Centres for Social Welfare offer subsidised home care services.

1.5. Integration of LTC

At the federal level, Integrated Home Care Services coordinate the provision of care in rather broadly defined geographical areas. They receive federal funds to finance multidisciplinary cooperation in primary care (mainly among GPs, nurses and paramedical professionals, together with the patient). At the regional level, home care is coordinated by the Cooperation Initiatives in Home Care (*Samenwerkingsinitiatieven Thuiszorg* or SITs); since 2010, SITs have been replaced by SELs *Samenwerkingsinitiatieven Eerstelijnszorg* [the Cooperation Initiatives in Primary Care] in Flanders, and by the Coordination Centres for Home Care and Services (*Centres de Coordination de Soins à Domicile* or CSSDs) in Wallonia. Their main task is to guarantee the quality of care and the cooperation among care workers involved in home care, including GPs, home nurses, accredited services of family aid, aid for the elderly and social work.

In addition to the initiatives to improve the coordination among various aspects of home care, special programmes and so-called 'care circuits' have been created to streamline the provision of care as patients move between care settings. An example is the care programme for geriatric patients who are discharged from hospital. The programme targets "in-depth interaction between the hospital and aid and care services at home and the general practitioner, particularly via an external liaison function developed within hospitals, in order to provide a 'care continuum'" (FPS, 2009, p.100). In Flanders, the recently implemented Decree on Residential

and Home Care (*Woonzorgdecreet* of 13 March 2009) stimulates the coordination and cooperation between residential and home care services.

2. Funding

Given the organisation of the Belgian LTC system, with its division of responsibilities between the federal and the regional levels, it follows that the financial flows are rather diverse and complex. Very broadly speaking, the portion of long-term care covered by the universal health insurance system (residential and home nursing care) is financed with social security contributions paid by workers, employers and retirees. Other LTC services and allowances are financed by general taxes, collected mainly at the federal level. A share of these taxes is used to contribute to the federal social security budget (including health care); another share is used for LTC subsidies and allowances at the federal and regional levels. It should be noted that social security contributions by workers, employers and retirees are not earmarked for the LTC (or even health care) budget. One notable exception is the Flemish long-term care insurance, which is financed by a specific contribution paid³ by every adult resident into a designated fund (the contributions make up approximately half of the annual budget, the rest is financed by general taxes).

Total LTC expenditures were approximately €5.7 billion in 2006,⁴ of which almost 98% was financed by a combination of social security contributions (59%) and taxes (39%). This figure does not include out-of-pocket payments for accommodation in residential care (approximately €2.3 billion). Generally speaking, LTC services provided through the federal health insurance system are financed by social security contributions (€2 billion) and taxes (€1.5 billion), while home care is financed by taxes (€728 million), out-of-pocket expenditures (€100 million) and specific contributions (approximately €54 million contributed to the Flemish Care Insurance scheme and allocated to home care). Table 1 gives a breakdown of total LTC expenditures in 2006 by funding source and care setting. It should be noted that not all out-of-pocket expenditures for LTC are known, since elderly persons who are not eligible for subsidised home care can and do buy these services privately, mainly by using ‘service cheques’. These are vouchers that can be purchased to pay for domestic services provided by public bodies or private firms who employ (usually low-skilled) personnel. The system was introduced in May 2003 in an attempt to regularise black economy activities in the domestic services sector. The services provided under this scheme are paid in large part by government subsidies (around €13 per hour), with the balance paid by the user (currently €7.5 per hour). This amount covers the hourly wage of the employee, including social security contributions, and a profit for the employer. The money spent on service cheques is tax-deductible by users up to a certain limit (implying that the government intervention is even greater than the subsidy). In 2008 the system cost around €1.3 billion. The amount spent on LTC is unknown, unfortunately, because the vouchers are used rather extensively to pay for domestic help other than help for elderly persons with IADL limitations (for instance by families with both spouses working full-time).

³ Currently this is €25 per year (€10 for persons qualifying for lower co-payments in the compulsory health insurance system).

⁴ This figure is an update of the System of Health Accounts (SHA) data provided to the OECD (see <http://stats.oecd.org/Index.aspx?DataSetCode=SHA>).

*Table 1. Long-term care expenditures by care setting and funding source (2006, M€)**

		Long-term care setting			
		Residential care	Home nursing care	Home care	Total
Source of funding	Contributions	2,018	1,295	54	3,367
	Taxes	1,505	-	728	2,233
	Out-of-pocket	1	7.2	99.3	107.5
	Total	3,524	1,302.2	881.3	5,707.5

* Excluding out-of-pocket expenses for accommodation in residential care and home care acquired with service cheques.

Source: Update of the System of Health Accounts (SHA) data provided to the OECD (see <http://stats.oecd.org/Index.aspx?DataSetCode=SHA>).

3. Demand and supply of LTC

3.1. The need for LTC (including demographic characteristics)

The ageing of the Belgian population – a demographic trend shared by most industrialised countries – is expected to be a major driver of increasing demand for long-term care services. Indeed, when it is assumed that the proportion of the elderly population with functional limitations will remain constant over time, the projected change in the age composition of the Belgian population over the next 40 years will result in a substantial increase in LTC needs and demand. To gain further insight into this likely trend, we first look at the available figures about LTC needs and use. For further reference, it is worth mentioning that of the total population of about 10.6 million in 2007, 1.8 million (17.1%) were aged 65 or older, and about half a million (4.6%) were 80 or older.

A major problem when analysing LTC demand is the fact that the need for care is not directly observed. What we do observe is the use of care, or more precisely, the use of formal care. To assess care needs, one has to rely on surveys in which respondents are asked questions about the limitations they experience. For Belgium, several such sources of information exist: the Census (2001), the Health Interview Survey (HIS, 2004) and the Survey on Health and Retirement in Europe (SHARE, 2004). Unfortunately, because of differences in the purpose of the questionnaires and phrasing of the questions, these surveys do not necessarily produce consistent prevalence rates. Using data obtained from SHARE, some 550,000 persons aged 50+ were in need of care in 2004, where need is defined as having ADL difficulties expected to last at least three months (at least difficulties with bathing/showering and dressing) or experiencing severe cognitive limitation (having difficulties with at least 8/10 items: reading, writing, orientation to time (two items – month and year), recall of ten words, verbal fluency, numeracy (three items – percentage, two-thirds and interest) and delayed recall of ten words). About 118,000 residential patients (a group not included in SHARE), all of whom fit the previous definition, were added to the SHARE numbers. The estimated number of elderly persons in need of care increases to 950,000 when a broader definition of need is used (defined as having at least one ADL or IADL difficulty expected to last at least three months).⁵

⁵ ADL refers to dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet. IADL refers to using a map, preparing a hot meal, shopping for groceries, making telephone calls, taking medications, doing work around the house or garden and managing money.

Under the assumption that the estimated prevalence rates of 2004 remain constant, it is possible to obtain the number of persons in need of care in the future, using recent demographic projections. This projection method is similar to the ‘pure demographic scenario’ used by the Working Group on Ageing (WGA) (2009). The results are given in Table 2.

The figures in Table 2 imply an average dependency rate of around 10% for men and almost 19% for women aged 50+ in 2007 (based on the 2004 SHARE results), going up to around 15% and 27% respectively in 2060. In absolute numbers there were about 566,000 persons with moderate to severe limitations in 2007, a number that, using current demographic projections, could increase to 1,168,000 by 2060. The doubling of the number of dependent persons is consistent with the WGA demographic scenario, although the absolute numbers reported here are somewhat higher (due to differences in estimated dependency rates in the base year).

Table 2. Current and projected number of elderly persons (aged 50+) in need of LTC

Age group	Population 2007		Dependency rates (%)		Persons needing care 2007		Persons needing care 2060	
	Men	Women	Men	Women	Men	Women	Men	Women
50-54	367,473	366,092	4.28	5.21	15,737	19,082	16,024	19,743
55-59	336,767	338,123	6.57	5.15	22,139	17,418	23,108	18,503
60-64	280,339	290,663	6.81	9.81	19,081	28,508	23,436	35,095
65-69	221,208	245,536	7.97	9.15	17,631	22,469	27,569	33,479
70-74	204,947	247,839	9.57	19.73	19,604	48,908	31,092	69,652
75-79	167,557	235,381	14.65	24.80	24,544	58,377	42,445	82,508
80-84	106,680	183,818	23.31	44.34	24,866	81,510	54,522	132,973
85+	57,266	144,663	58.23	77.82	33,344	112,576	158,488	399,733
Total	1,742,237	2,052,115	10.16	18.95	176,945	388,847	376,684	791,686

Sources: On population, the National Statistical Office (ADSED); dependency rates based on SHARE (2004 data); calculations by FPB.

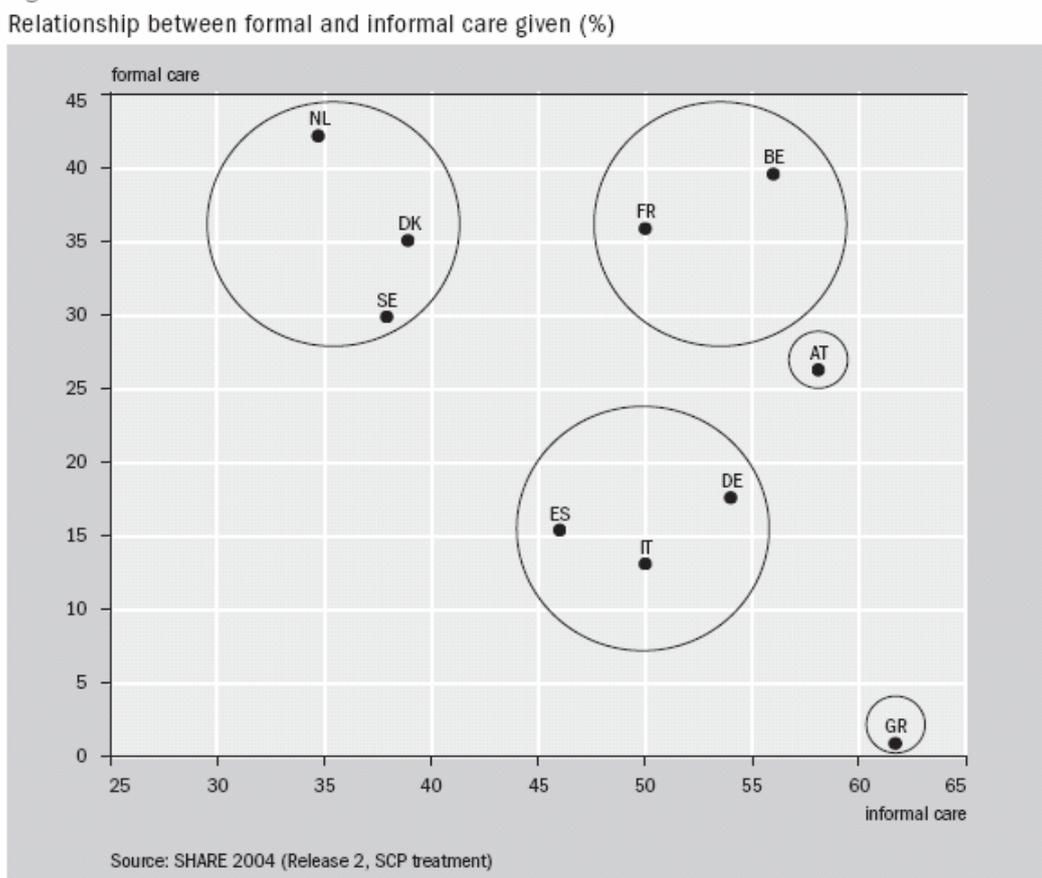
3.2. The role of informal and formal care in the LTC system (including the role of cash benefits)

Formal long-term care services are well developed in Belgium, with a diversified provision of residential, semi-residential, home nursing and home care services. It follows that the bulk of current needs as described in the previous section can in principle be met with the available supply. Of course, if needs grow in proportion to the share of the elderly population, supply will have to increase substantially to meet future demand. Ample formal care provision notwithstanding, care-dependent Belgian elderly also receive substantial informal care by relatives and friends. This places Belgium (together with France and Austria) somewhat outside the ‘core’ of European countries characterised by a trade-off between formal and informal care provision (and use), as illustrated in Figure 1. The rather intensive use of formal and informal care points at a problem that is sometimes mentioned with regard to the Belgian LTC system: some researchers (see e.g. Cantillon et al., 2009) claim that the provision of formal LTC is too indiscriminate, resulting in formal care being provided to elderly persons who have adequate

access to informal care, while providing too little to others with insufficient support from relatives or friends. We return to this issue in section 4.

Long-term care in Belgium is predominantly provided as a service in kind, with little or no co-payment for nursing care at home or in a residential setting. Two exceptions are the allowance for assistance to elderly persons and the Flemish Care Insurance, which are cash benefits aimed mainly at alleviating the burden of non-medical costs related to long-term dependency. These cash benefits may be used to compensate informal caregivers, but the recipient is in fact free to spend the allowance as he or she sees fit. As a rule, there is no choice between in-kind services and cash benefits.

Figure 1. Formal and informal care use in Europe (SHARE, 2004)

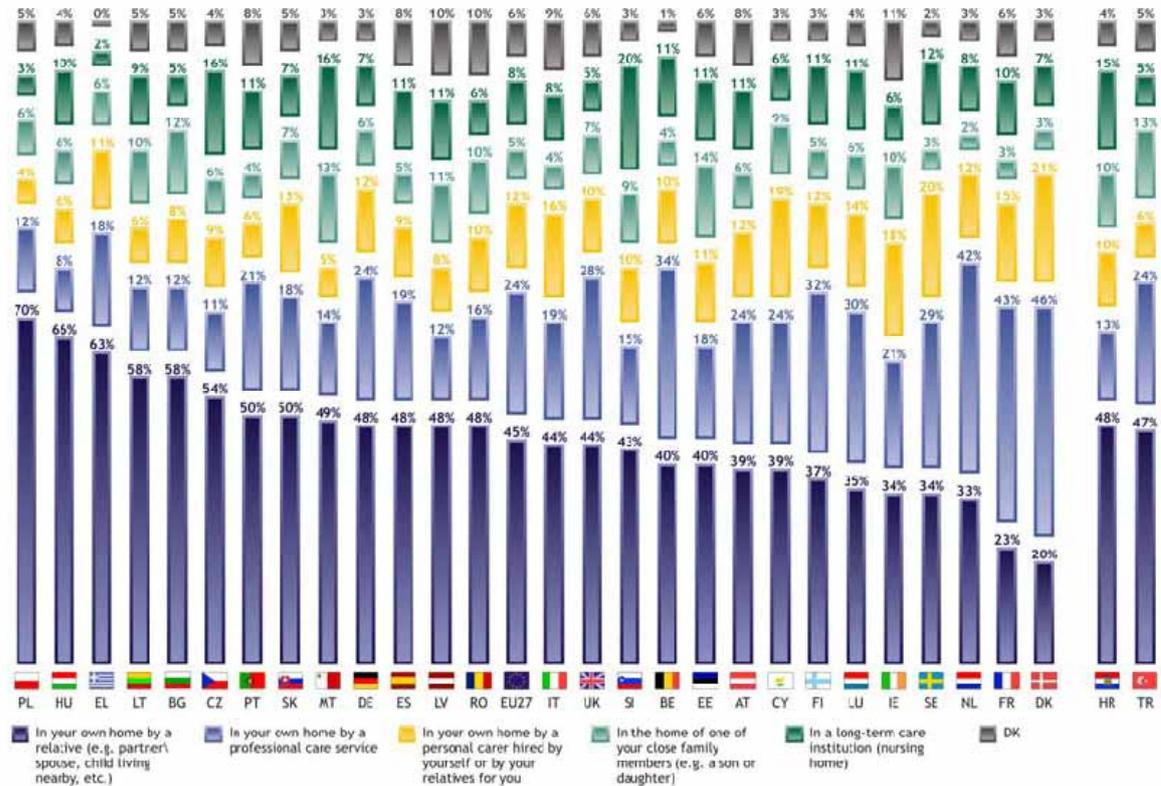


Source: Pommer et al. (2007).

Before discussing LTC supply and demand, it is worth mentioning how Belgians expect to be taken care of when they become dependent. This topic is discussed in a special Eurobarometer report published by the European Commission (2007). In this survey 28,660 Europeans aged 15 and over living in the 27 EU member states and the two candidate countries (Croatia and Turkey) were asked questions about their lifestyles, health limitations and attitudes to health and long-term care issues. One of the questions asked was the way in which they would prefer to be looked after if they were to become care-dependent. The answers are summarised in Figure 2.

Figure 2. Preferences of care setting and provision in Europe (2007)

Question: QAZ0b. And in which way you would prefer to be looked after?



Source: European Commission, *Health and Long-term Care in the European Union*, Eurobarometer (2007).

Despite substantial variations, a vast majority of Europeans would prefer to be cared for in their own homes, either by relatives or by professionals. Belgium is no exception, with 44% preferring care by relatives (40% in their own homes and another 4% in the home of a close family member) and 34% preferring professional care in their own home. The relatively high preference for professional care (45% versus 32% for the EU-27) is noteworthy. Only Denmark, France and the Netherlands rank higher in terms of preference for professional care.

3.3. Demand and supply of informal care

Demand and supply of informal care services, interpreted as the ex-ante willingness to use or provide them, is not directly observable for obvious reasons. The actual volume of this form of care, which could be labelled effective demand and supply, is quantifiable or at least estimable from survey data. Two prominent data sources, the 2001 Census and SHARE (2004), yield comparable results in terms of number of users and providers. Starting with informal care use, an estimated 200,000 persons aged 50+ who have at least one ADL limitation report receiving help from a relative or a friend in 2004. If a broader definition of care need is used (at least one ADL or IADL limitation), the number of informal care-users increases to around 777,000. These numbers were obtained using the SHARE informal care usage rates (number of persons receiving informal care as a percentage of the corresponding age group) with the 2004

population figures by age group. Not surprisingly, informal care use increases with age, but less so than care needs and total use. Consequently, the share of informal care in total care use declines as the severity of the limitations increases with age. Finally, it is worth noting that men use informal care relatively more intensively than women, with over 55% of men aged 50+ receiving informal care versus 42% of women. Two reasons can be put forward to explain this difference: first, higher life expectancy for women results in a greater availability of women caregivers. Second, a cultural gender bias may explain why men are more likely to expect being taken care of by their spouse than women are.

Turning to the provision of informal care, both the SHARE and the Census results indicate that a substantial fraction of the adult population provides care. Of course, with SHARE being limited to the population aged 50+, the number of informal caregivers (almost 400,000) obtained from it is surely underestimated. This is confirmed by the Census data, which yield an estimate of approximately 668,000 informal caregivers aged 15+ and 455,000 aged 45+ (these estimates were obtained using the 2001 Census probabilities of giving care applied to the 2004 population figures). The Census data have been studied rather extensively by Deboosere et al. (2006). In addition to the age distribution of the caregivers, they reveal (not surprisingly) that the probability of giving care depends on the gender and the occupational status of the potential caregiver, among other factors. Table 3 summarises these results.

Table 3. Probability of giving informal care by age, gender and occupational status (%)

Age group	Occupational status	Probability of giving informal care	
		Men	Women
15-24	Working	3.66	4.70
	Not working	3.84	4.80
25-44	Working	5.41	8.07
	Not working	9.89	11.39
45-64	Working	9.82	16.39
	Not working	12.63	17.54
65-74	Working	11.77	15.65
	Not working	11.63	12.96
+75	Working	17.72	17.54
	Not working	12.32	8.02

Source: Deboosere et al. (2006).

The results in Table 3 indicate that the probability of giving care increases substantially with age. Women are more likely to give care than men, especially in the age groups 45-64 and 65-74. Occupational status matters most, for obvious reasons, in the age groups 25-44 and 45-64. All else being equal, not working increases the probability of giving care in these age groups. Whether these caregivers are giving care because they are not working, or are not working because they are giving care, cannot be inferred from these aggregate figures. The probability of giving care not only depends on the age, gender and occupational status but also on the educational attainment and the household position of the potential caregiver. Generally

speaking, persons with lower educational levels are more likely to care for family within the household, while those with higher education are more likely to provide help outside the household (to both family and friends).

The socio-demographic characteristics that are associated with the probability of giving care are also linked to the intensity of care. In particular, women are somewhat more likely to provide intensive care, defined as providing more than two hours per day on average. Intensive care giving also increases with age and decreases with educational level. It is twice as likely for persons who are not working. Evidently, these results can be explained by the availability of time and its opportunity cost.

3.4. Demand and supply of formal care

Formal long-term care is provided in various forms, which differ according to the care setting and the type of care supplied. The care setting ranges from home (nursing) care to homes for the elderly and nursing homes, with a number of intermediate facilities such as ‘service flats’, day-care centres and short-stay facilities. Starting with the residential sector, there were some 123,000 mainly elderly persons living in homes for the elderly (73,000) and nursing homes (50,000) in 2007. Their numbers have increased steadily from around 90,000 in 1985, partly as a result of a gradual shift from hospital wards for long-term care patients to dedicated care facilities for elderly persons with chronic care needs caused by age-related limitations. It is important to note that not all the resident patients are necessarily dependent according to the usual assessment instruments based on the Katz scale. In homes for the elderly (*Rustoorden voor bejaarden*, labelled ROB), almost 25,000 residents technically need no ADL care and are in principle fit enough to live alone. The fact that they live in an ROB is due to ‘historical reasons’: the shift in LTC policy towards postponing the move from living at home to living in a nursing home is a rather recent one. This policy shift is illustrated by the fact that the number of low-care patients in ROB has remained quasi-constant over the past ten years, while the overall residential population has grown significantly. Another indicator of the recent trend towards de-institutionalisation is the growth in semi-residential facilities, such as day-care centres, short-stay centres and service flats. Table 4 illustrates this trend using Flemish data. These facilities are designed to allow elderly persons to keep living in their own homes or in accommodation suited to their needs.

Table 4. Recent developments in the supply of semi-residential care facilities in Flanders

Care setting	Unit of measurement	2000	2001	2002	2003	2004	2005
Day care	Accredited services	54	61	69	79	89	91
	Accommodation units	737	818	925	1,089	1,220	1,231
Short stay	Accredited services	68	76	93	110	128	142
	Accommodation units	280	313	385	483	576	649
Service flats	Units	10,121	10,640	11,419	11,876	12,312	12,797

Source: Vlaams Agentschap Zorg en Gezondheid (in Cantillon et al., 2007).

As Table 4 shows, the supply of semi-residential facilities has increased substantially in recent years. These services cater to the various needs of elderly persons: day-care centres offer LTC services for elderly persons who lack sufficient care at home, usually because informal caregivers are unavailable during office hours. Short-stay centres offer temporary residence for elderly persons who normally receive moderate to intensive informal care at home. Finally, service flats offer accommodation tailored to the needs and limitations of elderly patients whose own homes are no longer suitable for their condition. The elderly persons living in these flats do not need permanent care, but have easy access to various care services in the vicinity of their residence when needed.

The recent trend towards providing LTC services at home or in a semi-residential setting implies that residential care facilities are being reserved for severely dependent patients. This is confirmed by the gradual conversion of (lower care) ROB beds to (higher care) nursing home (*Rust- en verzorgingstehuis* or RVT) beds since 1985, and by the gradually increasing fraction of intensive care patients, many of whom combine physical limitations with moderate to severe mental impairments such as dementia. Table 5 provides the relevant numbers for selected years. It shows that barely 58% of all residential patients lived in homes for the elderly in 2007, down from almost 82% in 1996. The share of severely limited patients (defined as having at least three physical limitations or one physical limitation combined with being disoriented in space and time, labelled ‘high’ and ‘very high’ in Table 5) increased from around 58% in 1998 to more than 63% in 2007.

Table 5.A breakdown of residential patients by care level (selected years)

	Homes for the elderly (ROB)				Nursing homes (RVT)			Total
	<i>Severity of limitations</i>				<i>Severity of limitations</i>			
	Low to moderate	High	Very high	Total	High	Very high	Total	
1998	44,791	18,912	23,736	87,439	2,987	16,915	19,902	107,371
2001	45,521	18,130	17,988	81,639	7,512	30,103	37,615	119,359
2004	46,459	12,383	14,526	73,368	11,166	34,463	45,629	115,000
2007	47,011	11,858	14,277	73,146	14,761	34,950	49,711	118,840

Source: RIZIV; all data are patient counts on 31 March of the year in question.

Formal care at home consists of nursing care and personal and home help. The former is part of the federal public health insurance system financed by social security contributions and taxes, while the latter is organised at the regional level and financed by taxes. Home nursing care is provided by qualified nurses, many of whom are self-employed. Their services are covered by the public health insurance system if they have been prescribed by a physician. The level of care is determined by adding the scores (1-4) of the familiar six ADL items. In 2006 some 12,000 nurses provided care for about 146,000 patients. This headcount (of the nurses) should be approximately halved to obtain full-time equivalents. As for the patients, their numbers have gone up steadily since the late 1990s, as shown in Table 6.

Table 6. A breakdown of home nursing care patients by care level (selected years)

	Severity of limitations			Total
	Low to moderate	High	Very high*	
1997	88,707	28,112	0	116,819
2001	86,600	23,967	13,097	123,664
2004	105,978	26,929	15,297	148,204
2007	108,099	28,189	16,030	152,318

* In 1997 these patients were included in the 'high' category.

Source: RIZIV; all data are patient counts on 31 March for the year in question.

Comparing Tables 5 and 6, the shift to providing care at home rather than in nursing homes becomes apparent: the former has grown by 30% since 1997, while the latter has only increased 11% over approximately the same period.

Reliable evidence on the number of persons waiting for long-term care services and on waiting times is lacking. There is no central register and the residential facilities' lists are biased upward because elderly persons can be registered on multiple lists and providers fail to remove persons who are no longer likely to require admission. However, the available data seem to indicate that waiting lists and waiting times are longer in the Flemish Region than in the Walloon Region, for both residential care and home care (Devroey et al., 2001; Breda et al., 2002). Waiting times for home nursing care are short or non-existent.

Many elderly persons, who may or may not use home nursing care, receive formal home care. Estimates of their number vary rather substantially according to the data used. There were approximately 330,000 home care recipients aged 50+ in 2004 according to SHARE data, while Geerts and Breda (2007) report about 70,000 recipients of subsidised family care in 2005 in Flanders (which corresponds to roughly 120,000 for the whole of Belgium). According to the Belgian 2004 Health Interview Survey, about 140,000 persons aged 45+ report having used home care services in the past 12 months.⁶ The services provided include the delivery of hot meals (meals on wheels), help with domestic chores (laundry, ironing, cleaning and shopping, etc.) and basic personal help (like getting dressed). These services are organised locally. They are either provided by staff employed by a public agency or by private non-profit firms and financed by general taxes (subsidies) and the user (who pays a means-tested contribution). The subsidised home care sector produced about 25 million care hours in 2006, provided by the equivalent of 17,000 full-time workers. Total employment is even higher, since the figures include neither overhead personnel (such as administrative staff) nor other employees such as cooks, nor the personnel employed by social agencies and private firms using service cheques.

⁶ The difference between SHARE and the HIS data can be traced back to the wording of the questions: SHARE explicitly includes the use of privately purchased care services, while this type of help is not included in the HIS question. Furthermore, the SHARE figure includes recipients of 'meals on wheels', while this type of help was excluded from the HIS figure. The Flemish data in Geerts and Breda only refer to subsidised family care, so they exclude the use of meals on wheels and the use of cleaning services, as well as private care use.

The information described in this section is summarised in Table 7. The table shows the number of persons needing care according to a narrow and broad definition, the estimated number of users by type of care and the estimated number of carers in 2006. The number of carers excludes general practitioners and other staff working in the LTC sector such as administrative and technical personnel.

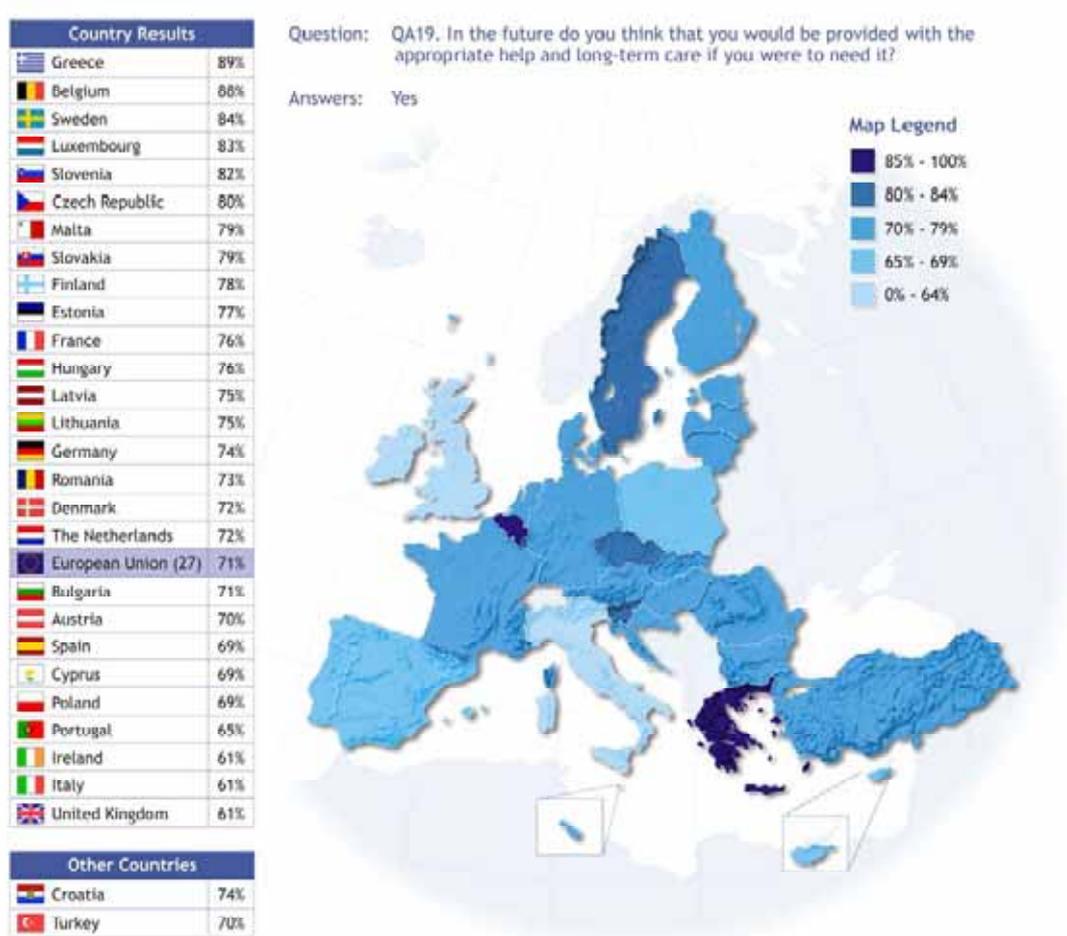
Table 7.A summary of LTC needs, use and resources in Belgium in 2006

Needs			
Narrow definition (2+ ADL)	550,000		
Broad definition (ADL or IADL)	950,000		
Type of care	Users	Carers	
Residential	122,000	39,000	FTE nurses
Home nursing care	145,000	5,000	FTE nurses
Home care	330,000	17,000	FTE helpers/carers
<i>Informal care</i>			
Narrow definition	200,000	400,000	SHARE (50+)
Broad definition	780,000	560,000	Census (15+)

Sources: For residential care, estimates based on Flemish data for the year 2000 (Pacolet & Cattaert, 2004), applied to the 2006 number of beds; on home nursing care, estimates based on the number of acts (RIZIV); on home care, estimates based on Flemish data (Vlaams Agentschap voor Gezondheid en Zorg).

A glance at Table 7 reveals no apparent gap between care needs and the available resources, at least at the aggregate level. Even with a very broad definition of care needs (anyone who has experienced at least one ADL or IADL limitation expected to last at least three months), there does not seem to be a marked lack of carers. It should be borne in mind, however, that the number of carers cannot simply be added because of the potential overlapping use of different types of care. At the same time, some elderly persons who feel slightly limited in IADLs do not necessarily feel they actually require formal or even informal help. Yet reassuring results at the macro level may well conceal imbalances between supply and demand at the micro level, so unmet needs may exist locally and/or for specific groups. With this caveat in mind, the apparent sufficiency of available care suggested by the macro data is corroborated by the expectation of receiving appropriate care, as expressed in the Eurobarometer survey. When asked, “In the future do you think that you would be provided with the appropriate help and long-term care if you were to need it?”, 88% of Belgian respondents answered positively, the second highest of the countries surveyed (see Figure 3).

Figure 3. Expectations about the appropriateness of care provision in Europe (2007)



Source: European Commission, *Health and Long-term Care in the European Union*, Eurobarometer (2007).

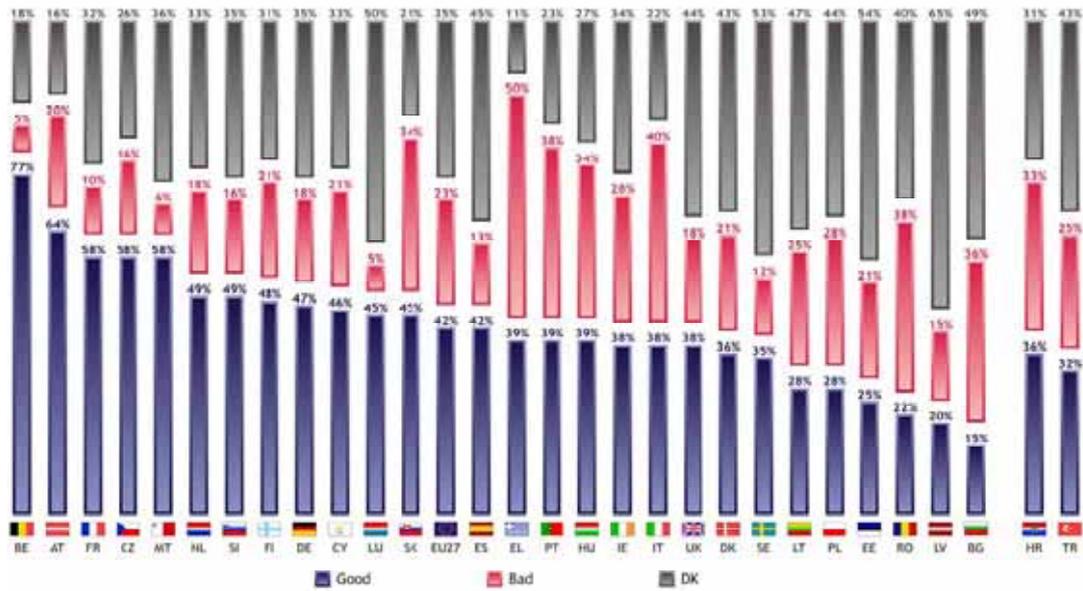
Belgians are not only optimistic about the provision of adequate care if they should need it, but also that the services they are receiving are of good quality. In home care, Belgians even rank first in terms of perceived quality of services (see Figure 4), while they rank second for perceived nursing home quality (Figure 5).

The apparent adequacy of current (aggregate) LTC provision, in terms of both volume and quality, provides no guarantee for the future. Indeed, with the possibility of a doubling of the dependent population by 2060 as a consequence of demographic ageing, keeping up current levels of care provision and quality standards will certainly be a challenge. It will require a sustained and increasing financial effort as well as careful human resource planning to ensure that the infrastructure and qualified nursing and caring staff are in place when the share of the elderly in the population reaches its maximum.

Figure 4. Quality assessment of home care provision in Europe (2007)

Question: QA3.5. Thinking now about your own experiences of health care services in (CUR COUNTRY) and those of people close to you, please tell me if you think that the quality of each of the following is very good, fairly good, fairly bad or very bad.

Option: Care services for dependent people in their home

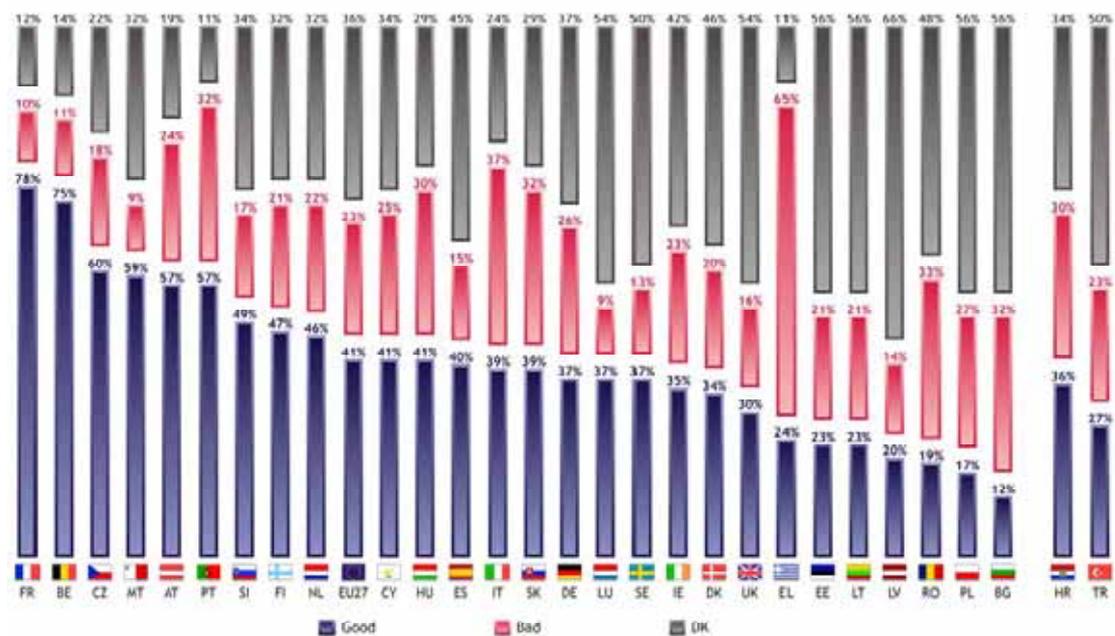


Source: European Commission, *Health and Long-term Care in the European Union*, Eurobarometer (2007).

Figure 5. Quality assessment of care provision by nursinghomes in Europe (2007)

Question: QA3.6. Thinking now about your own experiences of health care services in (OUR COUNTRY) and those of people close to you, please tell me if you think that the quality of each of the following is very good, fairly good, fairly bad or very bad.

Option: Nursing homes



Source: European Commission, *Health and Long-term Care in the European Union*, Eurobarometer (2007).

4. LTC policy

This section is based primarily on the *Strategic Report on Social Protection and Social Inclusion 2008-2010* (FPS Social Security, 2009).

4.1. Policy goals

The overall goal of Belgian LTC policy is to provide universal access to affordable and high-quality LTC, aimed, as in most European countries, at allowing the elderly care-dependent persons to keep on living in their natural environment (in their own homes) as long as possible. The targets of accessibility and affordability are at least partially met by the fact that residential care and home nursing care are part of the public health care system, which combines universal coverage with relatively low rates of out-of-pocket payments (at least for moderately to severely dependent patients). Nevertheless, the financial burden of non-medical expenses caused by the chronic nature of the limitations and disabilities associated with old age remains high. This has led to the introduction of various allowances, most of them means-tested, aimed at alleviating this financial burden for the chronically ill or dependent. To achieve the goal of delaying or avoiding the move of care-dependent elderly persons to (permanent) residential care (in homes for the elderly or nursing homes), a major policy goal is to diversify the provision of services, especially by creating so-called ‘transmural care facilities’ that provide short-term or temporary care to elderly persons who continue living in their own homes.

4.2. Integration policy

As noted earlier, at the regional level, home care is coordinated by the Cooperation Initiatives in Home Care (*Samenwerkingsinitiatieven Thuiszorg* or SITs; the Cooperation Initiatives in Primary Care (*Samenwerkingsinitiatieven Eerstelijnszorg* or SELs) since 2010 in Flanders, and by the Coordination Centres for Home Care Services (*Centres de Coordination de Soins à Domicile* or CSSDs) in Wallonia. As Coorens explains, “[t]heir main task is to guarantee the quality of care and the cooperation among care workers involved in home care, including GPs, home nurses, accredited services of family aid, aid for the elderly and social work, etc.” (Coorens, 2007, p.118). At the federal level, the government introduced Integrated Services for Home Care (*Geïntegreerde Diensten voor Thuiszorg* in Flanders and *Services Intégrés de Soins à Domicile* in Wallonia) in 2002. These services coordinate care provided in a specified geographical area and are composed of representatives of several health professions. Citing Coorens (2007, p. 118) once again: “The GDT-SISDs main task is to oversee the practical organisation and to support care providers and their activities within the framework of home care. In particular, this includes the evaluation of the patient’s ability to do things independently, the development and the monitoring of a health and welfare plan, the assignment of tasks between care providers and multidisciplinary consultation to reach the objectives.”

It should be noted that the division of responsibilities between the federal and the regional governments creates its own coordination problems, which are being addressed by working groups organised under the Inter-ministerial Public Health Conference. One of the results of their work is the formulation of common objectives by the Communities and regions in collaboration with the federal government. An outcome of this process has been the signing of Protocol 3 by the parties, which provides a budget for the Communities. The local authorities have some autonomy to use the budget. It can be used to convert ROB (homes for elderly) beds into nursing home beds, to increase transmural supply or to establish alternative types of care as well as new care functions in order to support home (nursing) care.

In addition to the initiatives to improve the coordination among various aspects of home care, special programmes and ‘care circuits’ have been created to streamline the provision of care as

patients move between care settings. An example is the care programme for geriatric patients who are discharged from hospital. The programme targets “in-depth interaction between the hospital and aid and care services at home and the general practitioner, particularly through an external liaison function developed within hospitals, in order to provide a ‘care continuum’” (FPS, 2009, p.100). In Flanders, the recently implemented Decree on Residential and Home Care (*Woonzorgdecreet* of 13 March 2009) stimulates the coordination and cooperation between residential and home care services.

4.3. Recent reforms and the current policy debate

Recent reforms in Belgian long-term care provision relate to measures aimed at improving access and affordability, available services, and quality. It should be noted that some of the reforms discussed below were not necessarily designed specifically for LTC patients, although many target the chronically ill.

Starting with access and affordability, a major and recent reform (effective since 1 January 2008) has been the extension of full health insurance coverage to the self-employed. Due to the extension, the self-employed – who were only covered for ‘major risks’ through the public mandatory health system before 2008 – are now fully covered for all risks. One implication for LTC is that formerly self-employed elderly are now covered for nursing care in homes for the elderly. Several reforms have also been implemented to alleviate the financial burden of the chronically ill. Probably the most comprehensive of these was the introduction of the Maximum Bill (*Maximumfactuur* or MAF) in 2001. This system sets a cap on the total medical bill that patients have to pay annually, limiting their co-payments in line with their income. The system is not specifically targeted at LTC, but since it was designed to limit the medical expenses of the chronically ill, elderly LTC patients are among the beneficiaries. Specific measures have also been taken for LTC patients, which may either take the form of a monthly or annual allowance to cover non-medical expenses, or a reduction in co-payments. An example of the former is the annual allowance for the use of incontinence materials; an example of the latter is the reduction of out-of-pocket payments for GP visits and home nursing care for severely limited patients as well as for GP visits to palliative patients in nursing homes and homes for the elderly.

The reforms related to the provision of services have focused mainly on offering a wider range of available services tailored to the various needs of the patients, as discussed in the previous section. This diversification is being accompanied by initiatives to improve the coordination among care providers in the various care settings (hospitals, nursing homes, day-care and short-stay facilities, home nursing, and formal and informal home care). Special attention is being given to supporting informal carers, who play a pivotal role in enabling dependent elderly persons to stay in their own homes. This support takes the form of providing informal caregivers with information and social and psychological support to alleviate the physical and mental stress that continuous care causes. It also comprises a well-established system of care leave for employees (to provide medical assistance and palliative care) and other leave schemes. In addition to the physical and psychological pressure, informal caregivers also face financial repercussions because of the time needed to provide care. To address this problem, the federal and regional governments are currently studying the possibility of developing new tax and social regimes aimed at reducing the adverse financial effects (and disincentives) faced by informal caregivers (FPS, 2009).

Quality assurance and improvement in LTC is to a large extent part of quality regulations in the overall health care system. Quality standards for institutions, for instance, are set for nursing homes just as they are for hospitals. Nevertheless, specific regulation is being developed in the LTC sector. For example, nursing homes are required to have a quality programme as well as training programmes for their staff (FPS, 2009). At the regional level, both the Flemish and the

Walloon regions have developed quality monitoring systems for nursing homes, day-care centres and homes for the elderly.⁷ These facilities are required to set up a quality manual specifying procedures and mechanisms that facilitate monitoring.

4.4. Critical appraisal of the LTC system

The overall aim of the Belgian health system is to provide citizens equal access to high-quality and affordable health and long-term care. This goal is achieved primarily by means of universal, mandatory, public health insurance, financed by social security contributions and taxes. It is probably fair to say that current LTC needs are adequately met by the provision of a diversified package of residential, semi-residential and home care services. As a result, Belgian citizens generally appear to be satisfied with the care they receive or expect to receive (European Commission, 2007). Some problems remain, however. First, the overall adequacy of LTC provision masks some regional imbalances. For example, rather substantial waiting times have been reported regarding admission in nursing homes. Second, some authors claim that LTC provision is too indiscriminate, resulting in a lack of focus on allocating the scarce resources to the patients who most need them (such as severely limited elderly persons who do not have sufficient informal care) (Cantillon et al., 2009). Third, notwithstanding the efforts to improve care coordination, LTC service provision remains complex and fragmented (partly because of the division of responsibilities between the federal and the regional levels). As a consequence, elderly persons and their relatives may have a hard time to obtain the help they need, despite the relative abundance of its potential supply (Geerts and Breda, 2007).

As regards affordability, substantial progress has been made with the introduction of the Maximum Bill, which appears to be rather effective in protecting the weaker segments of the population. Still, financial risks related to long-term care remain for some of the elderly, particularly in the south of the country. These risks are related to out-of-pocket expenses for items that are not covered by public health insurance (Schokkaert & Van de Voorde, 2005). Another concern that is frequently aired is the rather high price residents have to pay for accommodation in homes for the elderly and nursing homes. With an average pension of around €1,200 per month, many dependent elderly persons have insufficient recurrent income to pay their nursing home bill (which is around €1,500 per month on average). As a result, elderly homeowners sometimes have to sell their home when they move to a nursing home, while others receive financial support from their children. This support is not always voluntary, because the public agencies that financially support persons with insufficient income (the Public Centres for Social Welfare) have the right to claim money from the children. The duty for children to support their parents, which is the legal basis for this claim, is currently being debated, with some political parties in favour of lifting the duty.

To summarise the discussion of Belgium's long-term care system, it is probably fair to conclude that it provides sufficient and high quality care services given the current needs. The main immediate challenges are the coordination and integration of care in different settings and the affordability of care for financially vulnerable groups. In the longer run, however, given the projected share of elderly persons in the population in the decades to come, the overall financial burden of the system will become a major challenge. Moreover, the projected growing numbers of dependent elderly persons will pose the problem of finding equally growing numbers of informal and formal carers in order to maintain the current levels and quality of long-term care in the future.

⁷ The Flemish Ministerial Decree that regulates quality monitoring dates from 10 December 2001 – see *Belgian State Gazette*, 28 III 2002.

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Relevant website links

- Belgian Health Care Knowledge Centre (Federaal Kenniscentrum voor de Gezondheidszorg) (<http://www.kce.fgov.be/>)
- Census (Belgian Federal Government) (<http://statbel.fgov.be/nl/statistieken/gegevensinzameling/volkstelling/2001/index.jsp>)
- Federal Planning Bureau (Federaal Planbureau) (<http://www.plan.be/>)
- Federal Public Service Health (Federale Overheidsdienst Volksgezondheid) (www.health.fgov.be/)

Federal Public Service Social Security (Federale Overheidsdienst Sociale Zekerheid)
(<http://www.socialezekerheid.fgov.be/>)

Flemish Agency for Care and Health (Vlaams Agentschap Zorg en Gezondheid)
(<http://www.zorg-en-gezondheid.be/>)

Health Interview Survey (<http://www.iph.fgov.be/epidemiologie/epien/index4.htm>)

Health Portal (Portaal Gezondheid) (<http://www.belgium.be/nl/gezondheid/>)

Ministry of the Walloon Region – Division of Social Action and Health (Direction générale de l'Action sociale et de la Santé du Ministère de la Région wallonne)
(<http://socialsante.mrw.wallonie.be/>)

National Institute for Health and Disability Insurance (RIZIV - Rijksinstituut voor Ziekte- en Invaliditeitsverzekering) (<http://www.riziv.be/>)

Scientific Institute of Public Health (Wetenschappelijk Instituut Volksgezondheid)
(<http://www.iph.fgov.be/>)

SHARE (Survey on Health, Ageing and Retirement in Europe) (<http://www.share-project.org/>)

Statistics Belgium, Directorate-General Statistics and Economic Information (Algemene directie Statistiek en Economische informatie) (<http://statbel.fgov.be/>)

ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

L launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).