Belgium

Long-term Care

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Key Facts

- About 17% (OECD average 15%) of Belgium's population is aged over 65 and about 5% (OECD average 4%) over 80.
- In 2008, Belgium's expenditure on long term nursing care was equivalent to about 2% GDP, of which 1.7% GDP is devoted to institutional care.
- 6.6% (2007) of the population over the age of 65 are recipients of LTC in an institution; rate comparable to those found in the Netherlands, France and Switzerland (in the highest in the OECD).
- There are 71.1 long-term care beds per 1000 population aged 65 and over (one of the highest in the OECD) (OECD Health Data, 2010).

Background

Belgium is a federal state composed of communities and regions. Long-term care responsibilities are shared and divided among Belgium's levels of government, with community and region responsibilities generally complementing those of the federal state. Long-term care in Belgium is viewed as a health risk and institutional arrangements reflect a "medical model" of care delivery (as opposed to a welfare model).

Benefits and Eligibility Criteria

Belgium's public health insurance system (INAMI/RIZIV) provides for comprehensive universal coverage for all cost associated with acquiring assistance for daily activities (dressing, eating, washing, etc.) This benefit applies to assistance provided both at home and in an institution, subject to a personal contribution (i.e., ticket moderateur). Different measures exist to minimise out-of-pocket payments. One of the main measures is the MAF (*maximum à facturer/ Maximumfactuur*), which prescribes an upper limit on out-of-pocket payments associated with medical and nursing care for those with low-income or high chronic care needs.

There are also two major cash benefits targeted to individuals with ADL restrictions. At the federal level, the Allowance of the Elderly *(Allocation d'aide aux Personnes Agées / Tegemoetkoming Hulp aan Bejaarden)* provides a monthly benefit especially for low- and modest-income individuals 65 years or older with a given level of ADL and IADL restrictions. At the regional level, care insurance (*Zorgverzekering*) is a compulsory dependence insurance scheme, implemented by the Flemish government. It provides a flat monthly allowance of EUR130 to all eligible individuals who are assessed as having severely reduced or no ability to function independently (BEL scale).

In 2006, close to 50% of LTC recipients received care in an institution. Both rest homes and nursing homes can be public, private non-profit or private-for-profit. Institutional care is provided in two types of institution, rest homes (*maison de repos pour personnes agees/Rustoorden voor Bejaarden*) and nursing homes (*Rust-en Verzorgingstehuizen/Maisons de repos et de soins*). Rest homes target people with low to moderate ADL restrictions while nursing homes target people with moderate to severe ADL restrictions (Katz scale). In practice, there is some overlap between the two types of institutions and in the eligibility criteria for accessing an institution, which will always take into account the need for care but is not always transparent.

Institutional costs are typically divided between "care costs" and the accommodation cost ("hotel costs"). "Care costs" are covered by the INAMI/RIZIV and funding received from institutions from the INAMI/RIZIV varies according to the profile of residents in each respective institution (case-mix). The "hotel costs" (board, basic assistance and lodging) are generally covered bore by the users (around EUR1,185 a month on average). Individuals living in nursing homes exploited by a "Centre public d'action sociale" can be subject to lower accommodation costs and access to these centres is dependent on both a means test and the level of need for care. The number of institutional beds is subject to a "moratoire" -- a freeze on new institutional beds, in order to come to a further rationalisation of the bed offer.

In addition to rest homes and nursing homes, trans-mural care services (semi-residential care settings), such as day care centres and short stay care centers provides nursing care to individuals with moderate to severe ADL restrictions who remain in their own homes, but have limited or temporarily restricted access to informal care.

Home nursing care is available to all individuals with mild to severe limitations. The intensity of care is determined according to the level of ADL restrictions. Home care services may also include help with IADL limitations and personal care. For instance, the federal government subsidizes the purchase of in-house activities through "service cheques" for the entire population. At the regional level, eligibility for home care services and the number of hours provided generally depends on the severity of the patient's limitations and their financial situation. The range of home care services varies significantly across regions.

Funding and Coverage

The health care insurance system is funded through a number of channels, which includes social security contributions or payroll taxes (57%), general direct taxation (37%) and out of pocket payments (6%) via co-payments and co-insurance fees.

The federal allowances for the elderly and targeted social welfare benefits are financed through direct general taxation. The Flemish care insurance is financed through mandatory yearly contribution of EUR 40 a year from each person over the age of 25 and living in the Flanders. Home help assistance is generally financed through general taxation and out-of-pocket payments.

Caregivers

According to the 2009 Ageing report (European Economy), about 55% of dependent older persons received formal care at home or in an institutions while 45% relied only on informal (or no) care. In comparison, on average, approximately 60% of dependent older people relied only on informal or received no care in the EU 27. In 2006, about 685,000, or 9.4% of the population aged 15 and over, were informal carers in Belgium (Sesa, 2006). The majority of carers are women aged between 45 and 60 years of age.

For family caregivers, there are several possible ways to combine work and care. There are regulations mandating various forms of leave for carers. For example, under the time credit and the "interruption of career system", an employee is allowed to interrupt her/his career completely or partially for a limited period of time, with a monthly cash allowance while her/his social protection is fully maintained. In addition, every employee can take up to 10 days of unpaid leave each year for compelling reasons, including hospitalisation or illness of someone who lives under the same roof as the employee. However, this form of leave generally depends on the willingness of the employer and the financial position of the employee.

References

OECD 2009-2010 Questionnaire on Long-Term Care Workforce and Financing

OECD (2010) *Health Data 2010*, Paris.

OECD Social and Labour Demographics Database 2010