Long-term care – the problem of sustainable financing (Ljubljana, 18-19 November 2014)[1]

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1. How would you define the role of the state in your country with regard to long-term care (LTC) needs?

– As main provider/financer of LTC;

In Belgium, the role of the state is to provide a universal access to LTC services by financing various benefits in-kinds and in-cash. For benefits in-kinds, the public funding sources are fragmented at different institutional levels and the distinction between federal and other regionals level corresponds to the different types of care. Nursing care, including personal care in residential facilities and at home are financed at the federal level by the contribution of the workers, the employers and the retired (€ 3.3 billion in 2006) and by general taxes (€ 1.5 billion), while the costs of social care services (€ 728 million) (Willemé, Geerts, Cantillon, & Mussche, 2011) are mainly financed by taxes and regulated at the level of regions or municipalities. In Belgium, a number of regulations of services and of in-cash benefits target more specifically older dependent persons (+65 year-old).

Moreover, the state is also responsible of direct allowance to the older persons suffering from abilities limitations at the federal level which is transferred to the regional level since the sixth reform of the state in 2014. The cash benefits are allocated for non-medical expenses for all Belgian residents and financed by general taxes.

At last, the Flanders region, through general taxes, also contributes to the budget of the mandatory Flemish Care Insurance, mainly funded by the compulsory contributions of all adult residents in Flanders (and Brussels Capital Region on a voluntary basis). This insurance scheme specifically covers the non-medical out-of pocket expenses of dependent persons, providing a cash-for-care allowance (not mean-tested) which represents about € 54 million of contributions in 2006. (Anthierens et al., 2014; Willemé et al., 2011).

– As facilitator of private solutions (private insurance, support for informal carers);

Belgium is one of the rare countries to offer the possibility of a long duration leave to look after a dependent person (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). Different types of leave or flexible arrangements are possible according to the context. In private sector, for medical assistance, the employee receives an allowance as an income replacement and the contributions for pensions are also paid by the federal state. The entitlement is only granted for a severely-ill cohabitant of a family member up to the second degree for a maximum of 12 months leave. The leave time may also be claimed to care for a person for a maximum of 36 months leave, for a co-resident of a family member (including

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palliative care). In public sector, the legal arrangements are different but the same possibilities exist. The legal arrangements, to provide care and for medical assistance, can be combined to extend the leave. At last, the time-credit without any motives may also be taken for up to 12 months without any allowance.

When the public Flemish care insurance scheme has been created for non-medical expenses, commercial insurance companies were allowed to propose the same type of insurance but their market share remained very marginal (Willemé et al., 2011).

Has the role of the state evolved over recent years (passed or on-going reforms)?

In Belgium, the recent reform plans to transfer the competencies for long-term care from the federal to the regional level. As a consequence, residential facilities and cash benefits schemes will be entirely regulated at the regional level.

A possible reform for the informal caregivers is in discussion to recognise the status of informal caregiver through a specific allowance or specific working arrangements.

For home care services, the benefit in-kinds provided and funded at the municipal level will be extended (e.g. increase the ceiling of the total hours per beneficiaries, 200 hours to 250 hours per trimester) in order to allow a more intensive assistance at home for the dependent persons.

2. What are the public financing arrangements for long-term care in your country? Have there been any recent reforms related to the financing of long-term care or are there reforms under preparation?

At the federal level, the compulsory health insurance, financed mainly through the social security contributions paid by workers, employers and retirees, integrates an important part of the long-term care, the cost of personal care as a health risk, and rehabilitation care, both in residential settings and at home.

For health care services at home, the federal public intervention takes the form of fee-for-services for technical nursing interventions and a specific lump-sum above a certain threshold of ADL limitations (evaluated through an adapted Katz scale). In residential setting, for long term health care needs, the public federal payment mechanism is based on the level of dependency of the resident's case-mix per institution, according to the of the ADL limitations and the cognitive impairment. For this type of risk, there are no out-of-pocket expenses paid by the older person in residential facilities.

At regional level, the state finances home care (non-health related, such as family aid, meals-on-wheels…) by taxes allowing supporting, in priority, the persons with the greatest needs and with low-income (identified by a social worker). A co-payment is asked according to criteria depending on the region (the household financial resources in Wallonia, and the net monthly income, the intensity and duration of care, the household size and the level of dependency in Flanders). In Belgium the coverage of home care services, 5.5% in Flanders and Wallonia, is relatively high compared to other European countries (Germany, Italy). The monthly average cost per user is similar in the two regions (€ 65 in Wallonia and € 66 in Flanders) (Nyssens & Degavre, 2012).

A system of voucher is also implemented since 2001, financed by taxes at the federal level (from 2015, transferred to the regional level), but the entitlement does not depend on the level of ability limitations and is not mean-tested. The aim is to avoid undeclared workers for providing home care services at home,

(e.g. housework, meal preparation) or outside the residence (shopping, transportation for persons with mobility limitations or some specific chores, e.g. laundry or ironing). The public subsidies significantly reduce the labour cost through two funding sources. The first and the most important part is the direct payment of the care providers (in 2014 for the hourly cost total cost € 22.04, the federal intervention is € 13.54). The second federal intervention is a retrospective direct fiscal benefit to reduce from 30% the hourly cost paid by the user.

For non-medical expenses, at the federal level (and regional level from 2016), older persons (+65 year-old) can benefit from the Allowance for Assistance to Elderly Persons, a mean-tested allowance (considering all income in the household including the incomes from co-residents) financed by general taxes, varying between € 81 to € 549 per month. The granting depends on the loss of ability for performing ADL or IADL without any obligation on the use of the allowance.

The mandatory Flemish Care Insurances (*Vlaamse Zorgverkering*) is also another possibility of cash benefit in the Flanders which alleviates the cost of LTC. The cash benefit (€ 130 per month) is a lump-sum independent from the level of abilities limitations of which may not be sufficient to cover all non-medical expenses. The main advantage of this fixed allowance is a better control of the total expenses. The long term-care insurance scheme is mainly financed by the contributions of the residents in Flanders (€ 25 per year) and also by the regional taxes (Willemé et al., 2011). Since the access in the Brussels region is on an optional basis, the persons more at risk may be more interested in the affiliation to the insurance scheme. However, the adverse selection of risks does not seem to occur as the number of approvals stays relatively low in Brussels compared to the Flemish region (Karaya, 2009).

In Belgium, the different sickness funds, representing the historical political cleavages (5 national federations) play also a significant role in the financing of LTC. Alongside their central involvement in the administration of the mandatory health and disability Insurance, the sickness funds offer a complementary insurance to their members, which allow extending the height of the reimbursement and the range of the long term health care services covered. Their organisation differs from the private for-profit insurance since there is no risk segmentation and private profit is not legally allowed (Gerkens et al., 2010). Moreover, the sickness funds also finance the provision of social care at home either by directly providing services or through particular financial interventions for specific services (e.g. short term respite care at home) or through their participation in the funding of services provided by non-profit home care organisations. Indeed, the sickness funds have historical institutional links with the non-profit sector of home care organisations which provide an important variety of health and social care services such as nursing care, family help, occupational therapy, transportation, respite care at home, meals-on-wheels…

3. What is your experience with private (voluntary or compulsory) long-term care insurance? Have there been attempts of introducing private long-term care insurance in the past or are there any plans for the future?

No experience, stayed very marginal when introducing the Flemish long term care insurance scheme in 2001.

4. What share of the costs of LTC has to be borne by the person in need of care? What forms does this cost-sharing take? Has the extent of cost-sharing evolved over recent years or are any changes under preparation?

In Belgium, the compulsory health insurance covers more than 99% of the population. Overall, health care out-of-pocket expenses represent about 23.3% (Gerkens et al., 2010). For long-term health care expenditures, the patient cost-sharing is limited through a preferential status of reimbursement for low-income persons (mean-tested) and there are also mean-tested annual out-of-pocket maxima, i.e. a maximum of cumulative health care co-payments per year, granted according to the level of income of the household. Fixed co-payments are also granted for chronically-ill persons and for the use of continence material.

For home care services, the persons the most in need are targeted (low-income and with important limitations of abilities, both for ADL and IADL). For the persons with higher income, the system of voucher allows reducing the labour force cost for home care services, for the user, from € 22.04 to € 6.3 per hour in 2014. However, there might be a risk to have a category of person which cannot benefit from the two systems: too high income to benefit from the services provided by the region but which cannot afford the labour cost at € 6.3.

5. Which relatives/household members are responsible for a dependent person's care needs (providing care or by financing it)? To which extent are their assets and income protected against catastrophic care costs?

In Belgium, 12% of the population provide help to persons with ADL limitations, which represents a relatively high share regarding other European countries (Colombo et al., 2011). In a nation-wide study, among about 8,000 of the frail older persons living at home, 82% have an informal caregiver (co-residents and extra residents informal caregivers)(Macq et al., 2014).

At home, the main costs are directly linked to the caring activities and originate mainly from a loss of income for informal caregivers who reduce or cease their working activities. Studies of the impact on wages have contradictory conclusions (Bolin, Lindgren, & Lundborg, 2008; Heitmueller & Inglis, 2007; Lilly, Laporte, & Coyte, 2010) while the probability of labour force participation have been demonstrated to be influenced by informal caregiving (Bolin et al., 2008; Lilly et al., 2010; Masuy, 2009). However, the relation between caring and labour force participation is complex to analyse since the commitment to caregiving is likely to be also influenced by the labour force participation (Bolin et al., 2008; Heitmueller & Inglis, 2007; Lilly et al., 2010). Individuals who are employed full time or with high income have a high opportunity cost of caregiving and they are thus less likely to choose to provide informal care.

Some specific legal working arrangements may reduce the opportunity cost since it partially solves the dilemma between choosing of caregiving or working. In Belgium, the different legal arrangements on flexible working time bring in the opportunity to continue to participate to the labour force but the lump-sum allowance perceived does not compensate the full loss of remuneration due to the working time reduction.

In Flanders, a caregiver allowance is available at a local level, at different conditions of eligibility varying according to municipalities or communities (*Mantelzorgpremie*). The cash benefit aims to recognise the status of informal caregivers but does not constitute a direct cash compensation for the care

provided. The aim is only to fund the potential out-of-pocket expenses arising when caregiving (€ 30 in average per month in 2012) (Anthierens et al., 2014).

Another important expense for families in Belgium is the institutional cost in case of insufficient income to cover the board and lodging costs. Indeed, the cost of nursing home stays represents an important part of the private expenses which may not be affordable for an important proportion of the population. In 2010, the median of pensions is € 1,166 *(*not including the assets) while the price of nursing homes per month is € 1,226 in 2010 (SPF Economie, P.M.E., Classes Moyennes et Energie). In Belgium, legal obligations allow compelling the family to fund the board and lodging as maintenance obligations (spouses, children, grand-children, step-daughter or son-in-law). The Public municipal welfare covers these costs but only in last resort since the housing may also be required to fund the cost of nursing home stay. The Flemish long-term care insurance allows using the monthly allowance to fund these types of cost but the level of the lump-sum remains too low to significantly improve the grounds of affordability of the beneficiaries. The funding of the board and lodging costs in nursing home represents an important issue to tackle since the financial contribution of families of low-income relatives is likely to be more often required because of a higher prevalence of LTC needs in the low-income population.

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