ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Belgium

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Frederic De Wispelaere and Jozef Pacolet
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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by LISER and APPLICA, with the support of OSE - European Social Observatory.

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

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Summary / Highlights

Belgium's public expenditure on Long-Term Care (LTC) was relatively high in 2013 at 2.1% of GDP. Public expenditure on LTC is mainly the result of a high coverage of formal systems of institutional care and home care. Moreover, Belgium's level of legal entitlements for the reconciliation of work and care are relatively generous. As a result, it is considered a country with fully developed policies for the reconciliation of work and care.

In 2013, 9.4% of the Belgian population aged 15 and over indicated "they were informal carers. The percentage of informal carers increases with age, up to 15% for the 55-64 years age group . Also, a higher percentage of women are providing informal care (women: 10.9% vs men: 7.8%). Figures suggest that it is particularly persons with a low income who are providing informal help or care. Questions on the time spent on informal care reveals that 2 out of 3 informal carers of working age spent less than 10 hours per week on the provision of informal care, 16% spent 10 to 19 hours per week and 17% spent more than 20 hours per week. The time spent on informal care does not increase significantly with age.

Informal caregivers *(mantelzorgers, aidants proches)* are currently supported through home care, the service voucher scheme and by day centres, short-stay care centres, and old age/nursing homes which partly/fully alleviate the burden of informal caregivers. In recent years, a wide range of new and more diversified services have been developed and implemented that allow the provision of long-term care in settings other than a residential one. Combining care-giving with a career is further facilitated by carers' leaves. These leaves allow one to take time off to care for a needy person whilst receiving a replacement income. Figures reporting the average monthly amount paid for care leaves suggest that most of the persons are taking a part-time career break rather than a full-time career break. It consists of a temporary reduction of working hours rather than a full-time leave, with a subsequent return to the job. Moreover, the risk of poverty is (partly) reduced by combining part-time employment with part-time care leave. The broad coverage and the long duration of the carers' leaves are positive elements for persons of working age with dependent relatives. Nonetheless, a higher replacement rate could avoid informal carers showing high losses in income and a high at-risk-of poverty rate. In addition, we conclude that more efforts to increase awareness and knowledge about the entitlement to carers' leaves and long-term care benefits in cash and in kind are still needed to avoid a low take-up rate.

Finally, a major forthcoming challenge for Belgium will be to combine a higher level of employment (in order to reach the EU 2020 target of an employment rate of 75%) with a relatively high level of informal care. Despite the budgetary restraints, further development of both long-term care benefits in kind and carers' leaves is therefore essential in order to achieve a higher level of employment and a sustainable work-life balance for persons of working age with dependent relatives. In view of the ageing population, a growing share of informal care will be provided by the retired partner, sometimes already dependent. The growing need for professional care to support the main carer will contribute to further job creation.

1 Description of main features of Work-Life Balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime[1]

For decades, Belgium has had a well-developed social protection system covering the needs of dependent persons, such as persons with a disability, persons with chronic diseases, or elderly people. A wide range of residential and community care services have been developed and as well as systems of in-cash allowances to compensate the additional costs of dependency and care leaves.

Long-term care is part of an integrated system of health care complemented by social service provision. The organisational landscape of long-term care provisions is fragmented because of a division of competencies between the Federal Government (responsible for medical care through the health care system) and the Communities (responsible for non-medical care). As a result of the sixth state reform since July 2014, the division of competencies between the different state entities is set to change in order to increase the homogeneity of competences, allowing policy to better meet local needs. Aspects of long-term care are being transferred since July 2014 from the federal level to the Communities, and many of these new competences involve direct service delivery to patients. This represents a shift whereby not only home care but also intra-mural care will be more in the hands of the Communities, allowing for different regional policy accents and priorities to emerge and develop. In Flanders, for instance, the new competences will be integrated in a so-called Flemish Social Protection system 'Vlaamse Sociale Bescherming'.

The maintenance obligation applicable to parents for their children is reciprocal (Articles 205, 207 and 353-14 of the Belgian Civil Code).[2] Children therefore have a maintenance obligation towards their parents if they are in need.

1.2 Description of carers' leaves[3]

1.2.1 Time credit leave *(tijdskrediet/Crédits temps)* with a specific reason

Workers can take a full-time or part-time career break or a one-fifth working time reduction for a specific reason *inter alia* to provide palliative care (for a maximum of 36 months), to support seriously ill relatives (for a maximum of 36 months) or to provide care to a disabled child (for a maximum of 48 months).[4] Payment varies according to age, civil status and years of employment. The maximum benefit for a full-time break with at least 5 years of employment is approximately EUR 641 per month (indexed amount applicable since 2012).

- **Thematic leaves: Career break in the context of leave for medical assistance or for palliative care** (Loopbaanonderbreking in het kader van de medische bijstand of palliatief verlof/ Interruption de carrière dans le cadre d'un conges pour assistance médicale ou pour soins palliatifs)

[1] Based on Segaert (2014) and Schepers et al. (2016).

[2] See the European Judicial Network (maintenance claims- Belgium).

[3] The Belgian government has recently (7th of April 2016) announced a reform of the statutory working time that should favour an increase in flexible working. The reform aims to replace the weekly calculation of working hours with an annual basis. The idea is to increase the legal maximum working week from 38 to 45 hours, but only on the condition that when calculated on an annual basis the average week remains at 38 hours. So in practice, an employee could, for example, work a 45 hour week with 9 hour working days, and compensate with shorter days during the year.

[4] See also National Employment Office http://www.rva.be/nl/documentatie/infoblad/t131

Workers can take a career break to provide medical assistance to a family member suffering from a serious illness or to provide palliative care.[5] The career break to provide medical assistance enables work to be suspended or reduced (depending on the case and per patient for a maximum of 12 or 24 months for complete discontinuation or a maximum of 24 or 48 months for partial discontinuation), in order to assist or provide care for a member of the household or up to a second degree family member who has a serious illness. There is also the possibility to suspend work for one week in the event of the hospitalisation of a child aged below 18. The career break to provide palliative care enables work to be suspended or reduced (for a maximum of 2 months per patient), in order to assist or provide care for those with an incurable disease and who are in the terminal phase. These thematic leaves qualify for a flat-rate benefit of approximately EUR 787 per month (gross amount) (indexed amount applicable since 2012) in case of a complete suspension of the full-time employment, paid by the National Employment Office *(RVA/ONEM)*.

1.2.2 Palliative care for self-employed persons (since October 2015 called 'uitkering mantelzorg'/allocation d'aidant proche)

Self-employed persons can receive a benefit if their child is seriously ill or if their child or partner is in need of palliative care. This arrangement has been changed (in case the partner or up to second degree relatives are seriously ill or in need of palliative care) and expanded (including care for a disabled child aged below 25) since October 2015 *('uitkering mantelzorg')*.[6] The self-employed activities can be suspended completely (100%) or partially (at least 50%). The monthly payment amounts to EUR 1,092 in case of a complete suspension of self-employment activities and to EUR 546 in case of a partial suspension. The self-employed person is entitled to receive this allowance for a maximum period of 12 months during his/her entire career. In case of a complete suspension of the self-employment activities for a period of three months, the self-employed person is entitled to an exemption from social security contributions for one quarter without losing their social security rights. This exemption is limited to four quarters during his/her entire career.

1.3 Description of carers' cash benefits

1.3.1 Child benefits: Supplementary allowance for children with disabilities under the age of 21

A supplement will be paid above the ordinary child benefit. This supplement varies according to the degree of disability. However, with the implementation of the sixth state reform, since July 2014 the payment of the child benefit has become the responsibility of the Communities.

Expenses related to non-medical long-term care are borne by the individual, but offset by several **cash benefits**.

- A monthly **allowance for assistance to the elderly (AAE)** (*Tegemoetkoming voor hulp aan bejaarden/ Allocation pour l'aide aux personnes âgées*) is granted to persons aged 65 and older for whom a severe need for care is ascertained (DG Disabled Persons, 2013). The granting is subject to income conditions. The amount of the allowance depends on the degree of dependency (5 categories).[7] In the sixth state reform, this allowance has been transferred to the Communities.

[5] See also National Employment Office http://www.rva.be/nl/documentatie/infoblad/t18 and http://www.rva.be/nl/documentatie/infoblad/t20

[6] See Social Security Self-employed Entrepreneurs http://www.rsvz.be/nl/news/een-uitkering-bij-mantelzorg-door-zelfstandigen

[7] The maximum annual amount of the AAE varies between EUR 981.68 (category I) and EUR 6,589.77 (category V).

- The **integration allowance (IA)** for those persons with a handicap *(Integratietegemoetkoming/Allocation d'intégration)*. This allowance can be granted to disabled persons (aged between 21 and 65, with some exceptions) to compensate for the extra costs they have to make to integrate into society (DG Disabled Persons, 2013). The granting is also subject to income conditions. The amount of the allowance depends on the degree of dependency (5 categories).[8] Although very similar to AAE, this allowance has not been transferred in the sixth state reform to the Communities.
- Flanders introduced an additional **"Flemish Care Insurance"** (*Zorgverzekering*) in 1999, covering the costs of non-medical help and services borne by people with reduced self-sufficiency. The system is organised as a residence-based compulsory insurance-type scheme: every person residing in Flanders is obliged to be covered; persons residing in Brussels are allowed, but not obliged, to join. Note that the *'zorgverzekering'* only provides financial benefits; insurance under the scheme is not a requirement for receiving long-term care services.[9] It is financed by a flat compulsory contribution of EUR 25 per year for each person older than 25 years, reduced to EUR 10 for lower income groups. The budgetary measures of the new Flemish Government Bourgeois I (2014) increased this contribution to EUR 50 and EUR 25 respectively from 2015 on.
- At Flemish level the **VAPH** (the Flemish Agency for Disabled Persons) pays a Personal assistance budget (PAB) to disabled persons who prefer to live at home. This budget can enable them to employ a personal carer/helper. In the Walloon Region the Walloon Agency for the Integration of Disabled People **(AWIPH)** is responsible for similar benefits. The same goes for the Brussels region where **PHARE** is a service for the French speaking community of Brussels with responsibility for financing those benefits for the French speaking part of the population.

1.4 Description of carers' benefits in kind

There are several long-term care benefits in kind in Belgium.

- **Home care** includes non-medical services. Non-medical home care services are regulated and organised by the Communities. These services include help with personal care tasks (e.g. help with eating or moving around, hygienic help) along with instrumental help (e.g. light housework, preparing meals).
- **Medical home nursing care**, which consists of services such as wound dressing and drug administration.
- In centres for **day care** and "short-stay" care, nursing care and personal care are provided to elderly persons for whom home care is temporarily unavailable. This is meant for people who do not need intensive medical care but who require care or supervision and aid in the activities of daily living. A fixed daily compensation is paid by the compulsory health insurance.
- Elder persons who do not require much care can also be serviced in a semi-residential setting, where individual living arrangements are combined with collective facilities such as meal services or home help services. These arrangements are commonly known as **"service flats"**.

[8] The maximum annual amount of the IA varies between EUR 1,148.76 (category I) and EUR 10,337.70 (category V).

[9] More information on the Flemish care insurance can be found in the year reports of the Flemish Care Fund, accessible via http://www.zorg-en-gezondheid.be/jaarverslagen-vlaams-zorgfonds . Updated figures are posted on http://www.gezondheidsconferentie-kankeropsporing.be/Cijfers/Cijfers-over-de-Vlaamse-zorgverzekering .

- A residential **old age home** is a home-replacing environment where the medical responsibility rests with a general practitioner. The residency costs are paid by the occupant, while medical costs and the cost of care are covered by the compulsory health insurance scheme based on an objectively assessed degree of care needed.
- Patients with moderate to severe limitations who do not need permanent hospital treatment are admitted to **nursing homes** (*Rust- en verzorgingstehuis* (*RVT); maison de repos et de soins (MRS)*). Each nursing home must have a coordinating and advisory physician who is responsible for the coordination of pharmaceutical care, wound care and physiotherapy. Each rest and nursing home must always have a functional link with a hospital. They must cooperate with the geriatric service of the hospital and a specialised service of palliative care. While patients must finance the residency costs themselves, nursing care is reimbursed by the compulsory health insurance.
- At Flemish level the VAPH (the Flemish Agency for Disabled Persons) subsidises **services and institutions which provide care for disabled persons** through day care or guidance. The current financial system has been revised and is replaced by a personal budget 'Persoonsvolgende Financiering' (PVF) provided to the person with a disability (since April 2016).[10]

The Service Voucher Scheme

An important objective of the Service Voucher Scheme is to contribute to people's work-life balance. Activities can take place both inside (cleaning, ironing, preparing food and doing occasional sewing work) and outside (ironing, shopping, supervised transport of persons with reduced mobility). Each adult living in Belgium can buy up to 500 service vouchers per year. Each family (persons living in the same household) can buy a maximum of 1,000 service vouchers per year. A limited number of categories are even allowed to buy 2,000 service vouchers per year. This applies, *inter alia*, to disabled users and parents with a disabled child. The first 400 vouchers cost EUR 9 each, the remaining 100 vouchers EUR 10 each. However, the user is eligible to a tax credit of 30 per cent on his personal income tax, reducing the real user cost per voucher to EUR 6.3 for the first 400 vouchers, and to EUR 7 for the remaining ones. However, with the implementation of the sixth state reform, the Service Voucher Scheme has become the responsibility of the Communities.

[10] See the Flemish Agency for Disabled Persons http://www.vaph.be/vlafo/view/nl/9671459-Persoonsvolgende+financiering+%28PVF%29.html

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

2.1.1 Carers' leaves

Time credit *(Tijdskrediet / Crédits temps)* with a specific reason and career break in the context of leave for medical assistance or for palliative care

(Loopbaanonderbreking in het kader van de medische bijstand of palliatief verlof/ Interruption de carrière dans le cadre d'un conges pour assistance médicale ou pour soins palliatifs)

The career break in the context of a leave for medical assistance (15,461 claimants in 2014) has become a particularly highly appreciated carers' leave. The number of claimants increased in 2014 by roughly 15% compared to 2013 and by 178% compared to 2007 *(Table 1)*. Also based on figures for June 2007, approximately 3 in 4 claimants of a carers' leave for medical assistance or for palliative care were female.[11]

Table 1 Time credit with a specific reason and career break in the context of leave for medical assistance or for palliative care, Belgium, 2007-2014

	2007	2011	2012	2013	2014	% change 2007 - 2014	% change 2013 - 2014
Time credit with a specific reason (number of persons entitled)							
Provide palliative care			8	8	20		141.5%
Support to seriously ill relatives			539	1,004	1,151		14.6%
Provide care to a disabled child			119	287	409		42.4%
Medical assistance							
Number of persons entitled	5,554	10,256	11,443	13,470	15,461	178.4%	14.8%
Average monthly amount (in EUR)			355	364	366		0.6%
Palliative care							
Number of persons entitled	205	226	251	269	291	42.0%	8.2%
Average monthly amount (in EUR)			339	341	350		2.6%

Source: National Employment Office, Annual Reports 2014 and 2012.

Figures reporting the average monthly amount paid by the National Employment Office (on average between EUR 350 and EUR 400 for 2014) *(Table 1)* suggest that most of the persons are taking a part-time career break rather than a full-time career break (see also Frans et al., 2011). It results in a temporary reduction of working hours rather than a full-time leave with a return to the job after the period of care leave. Moreover, the risk of poverty is (partly) reduced by combining part-time employment with part-time care

[11] See the statistics published on www.werk.belgie.be

leave given that the level of payment for persons with a dependent relative is mostly less than the poverty threshold.

Palliative care for self-employed persons (since October 2015 called *'uitkering mantelzorg' / allocation d'aidant proche*)

Only a limited number of self-employed persons (22 in 2011)[12] made use of the old arrangement (before October 2015). No figures are available yet on usage of the new arrangement (since October 2015).

[12] Parliamentary question to the Minister for the Self-employed Sabine Laruelle.

2.1.2 Carers' cash benefits

Child benefits: Supplementary allowance for children with disabilities under the age of 21

A supplementary allowance was paid to 58,937 children with disabilities (situation at 31 December 2014) (Federal Agency for Child Benefits, 2015).

- **Allowance for assistance to the elderly (AAE)** (Tegemoetkoming voor hulp aan bejaarden / Allocation pour l'aide aux personnes âgées) and the **integration allowance (IA)** (integratietegemoetkoming / allocation d'intégration)

In 2014 some 153,000 persons benefited from an IA and a similar number of persons received an AAE *(Table 2)*. The number of claimants of an AAE increased in 2014 by 11% compared to 2009.

Table 2 Number of claimants AAE ad IA, Belgium, 2009-2014

	2009	2010	2011	2012	2013	2014	2014 (excl. IRA)
IA-IRA*	152,694	158,662	160,071	163,336	166,903	170,687	153,014
AAE	138,626	145,945	150,846	152,159	153,361	154,482	

* Sum of claimant IA and/or IRA: The income replacement allowance (IRA) can be granted to persons who are not able to earn more than 1/3 of what an able-bodied person can earn by working.

Source: Statistics DG Disabled Persons

2.1.3 Carers' benefits in kind

Residential care

In a recent report published by the Belgian Health Care Knowledge Centre *(KCE)* (Vrijens et al., 2015) we read that there is a rather wide gap between Flanders and Wallonia/Brussels concerning the number of beds in homes for the elderly, and consequently in the share of population residing in a residential care service or at home. Percentages of institutionalised elderly are higher in Wallonia and Brussels than in Flanders.

The cost to the patient of a sojourn in a retirement home is estimated to be around EUR 1,455 per month (EUR 48.5 per day without supplements, 2012 data, in Flanders), compared to the average monthly legal pension of about EUR 1,220 (figures for Belgium, 2007) (Pacolet & De Coninck, 2015; FOD Sociale Zekerheid, 2011). Moreover, inspections in retirement homes reveal that institutions sometimes charge extra costs that should be included in the normal price (supplements). If a care-dependent person is not able to pay the bill, children are (legally) required to contribute *(see Section 1.1)*. If this proves impossible, the unpaid cost is covered via social assistance. The Flemish Care Insurance (*Zorgverzekering*, EUR 130 per month) and the federal allowance for assistance to the elderly (AAE) also contribute to better affordability. This helps to bridge the gap between the cost of residential care and the pension. Roughly 75,450 dependent persons in residential care were entitled to a benefit from the Flemish Care Insurance in 2014 (Agentschap Zorg & Gezondheid, 2015).

Home care

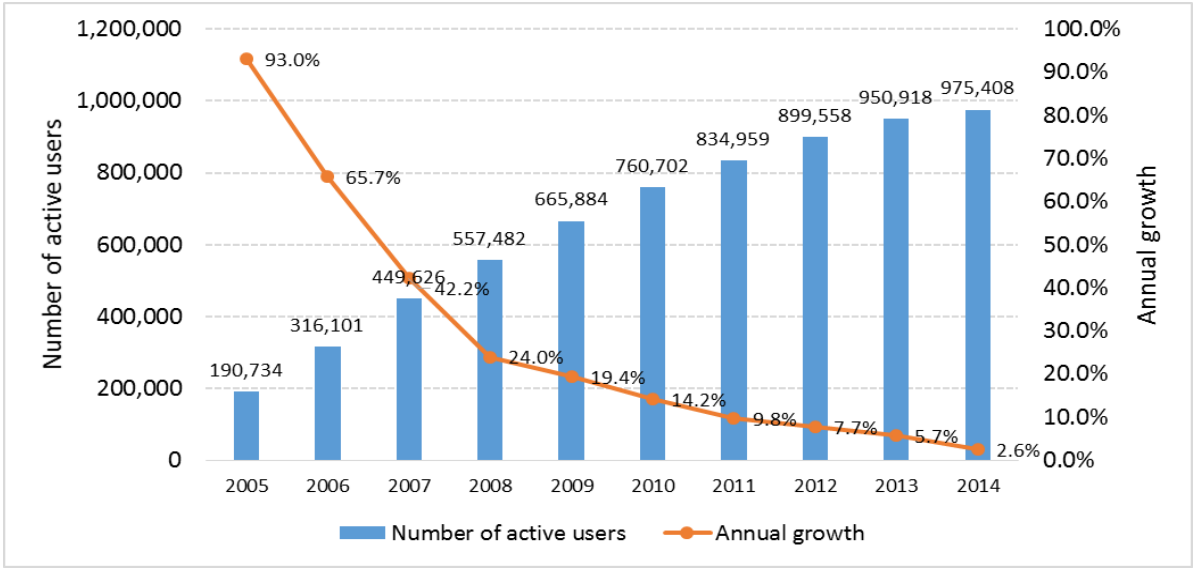
Home care services are organised locally. Based on figures from the most recent Health Interview Survey (HIS) of the Scientific Institute of Public Health (2013) no significant

differences in use of home health care services can be observed by income level.[13] To pay for the part of the bill that is related to non-medical care, a federal means-tested monthly allowance for disabled persons and the elderly is complemented by, in the Walloon region, increased financial support for family assistance and, in Flanders, by a separate care insurance (Flemish Care Insurance). In 2014, the Flemish Care Insurance provided a benefit of EUR 130 per month to 162,500 individuals receiving home care (Agentschap Zorg & Gezondheid, 2015). As of 1 June 2013, the benefit is awarded automatically in some cases, without the need for applying. This compensation is however not sufficient to cover the non-medical costs of many patients who receive care at home. For this reason, the Flemish government plans to introduce a "Maximum Billing System" for home and residential care in Flanders (Pacolet et al., 2010). With the sixth State Reform, those plans will be integrated in the coming Flemish Social Protection System 'Vlaamse Sociale Bescherming'.

The Service Voucher Scheme

The Service Voucher Scheme has become a very popular initiative. In 2013, there were approximately 975,000 active users, who used on average 119 vouchers per user *(Figure 1)*. If we look at the coverage rate for 2013 – the number of households using service vouchers divided by the number of total households - roughly 1 in 5 Belgian households are making use of this scheme (IDEA Consult, 2014). Between 2005 and 2014 the number of active users increased significantly. Nonetheless, the annual growth has slowed, which could be an indication that the scheme has reached maturity. In 2013, 72% of the users were aged below 65. A second group are users above 65 with specific care needs. Moreover, this group of users increased between 2008 and 2013 from 25% to 28% of total users.

Figure 1 Use of the Service Voucher Scheme, Belgium, 2005-2014



Source: Statistics of the National Employment Office

Marx and Vandelannootte (2014, p. 2) conclude that "there is little evidence that the scheme has significantly boosted participation rates or working hours". Nonetheless, the scheme could be considered as an important tool to help people of working age achieve a better work-life balance but also to increase female participation in the labour market. After all, 11% of the users indicate that they would have worked fewer hours without the scheme and a similar percentage of users indicate that they even work more hours *(Table 3)*.

[13] See also for the interactive analysis of the HIS https://hisia.wiv-isp.be/SitePages/Home.aspx

Table 3 Impact of the Service Voucher Scheme on employment, Belgium, 2010

	% of total
Yes, return to work	0.6%
Yes, work more hours	10.7%
Yes, otherwise less hours	10.8%
No impact	78.0%
Total	100.0%

Source: Idea Consult, 2011

The gross price per service voucher has increased for the user from EUR 6.2 in 2004 to currently EUR 9. Despite the higher cost for the user the scheme remains heavily subsidised as roughly 70% of the total cost is borne by the State (Pacolet et al., 2011; Marx & Vandelannootte, 2014). Pacolet et al. (2011) found that service voucher workers increasingly perform care tasks, especially for elderly and disabled persons. It might result, mainly because of the low price per service voucher, to a displacement of existing systems of home care.

2.2 Assessment of overall package of measures and interactions between measures

Belgium's public spending on LTC was 2.1% of GDP for 2013 (EC, 2015). By way of comparison, only Norway, the Netherlands, Sweden, Finland and Denmark show a higher public expenditure on LTC. Public expenditure on long-term care in Belgium is mainly the result of a high coverage of formal systems of institutional care and home care. Moreover, the coverage rate (LTC recipients as % of dependent population) is only higher in Norway and Finland. In 2013, a total of 13.3% of the Belgian population aged 65 years and over was receiving LTC, either in residential care (8.4%), or at home (4.9%) (Vrijens et al., 2015). Moreover, Belgium's level of legal entitlements for the reconciliation of work and care are relatively generous (Eurofound, 2015). As a result, it is considered a country with fully developed policies for the reconciliation of work and care (Ibid.).

Informal caregivers *(mantelzorgers, aidants proches)* are currently supported through information provision, social and psychological services and by day centres, short-stay care centres, old age/nursing homes which partly/fully alleviate the burden of informal caregivers. In recent years, a wide range of new and more diversified services have been developed and implemented that allow the provision of long-term care in settings other than a residential one. Combining care-giving with a career is further facilitated by carers' leaves. These leaves allow one to take time off to care for a needy person whilst receiving a replacement income. The duration of these leaves are mostly sufficiently long. However, the level of payment for persons with a dependent relative (i.e. replacement rate) is mostly less than the poverty threshold.

In the 2010 SHARE survey,[14] Belgium had the highest proportion of the population aged 50 and older declaring to be informal carers (20.6%, compared to OECD-18 average of 15.6%) (Vrijens et al., 2015). In 2007, this proportion was only 12%. In the most recent Health Interview Survey (HIS) of the Scientific Institute of Public Health a chapter is for the first time dedicated to the number of informal caregivers and the time spent on informal care (Demarest, 2015; Vrijens et al., 2015).[15] In the survey the definition from the European Health Interview Survey is applied (i.e. the provision of help in ADL activities (activities of daily living) or personal care at least once a week). In contrast to the SHARE data, the age limit is set at 15 years and older instead of 50 years and older. Overall, 9.4% of the Belgian population aged 15 and over indicated they were informal

[14] See also http://www.share-project.be/

[15] See also for the interactive analysis of the HIS https://hisia.wiv-isp.be/SitePages/Home.aspx

carers *(Figure 2)*. The percentage of informal carers increases with age up to 15% for the 55-64 years age group. The at-risk-of poverty rate within the age group 50 to 64 years, the age group with the highest percentage of informal carers and probably also the age group with a higher average income compared to the other age groups, is 11.8% (compared to a total at-risk-of poverty rate of 15.5%) (FOD Economie – Statistics Belgium).[16] Also, a higher percentage of women are providing informal care (women: 10.9% vs men: 7.8%). Based on these results, the authors of the recent KCE study concluded (Vrijens et al., 2015, p. 284) that: "the increase in the proportion of informal carers in Belgium is a strength for the Belgian health system, however this kind of caregiving is also associated with a reduction in labour force attachment for caregivers of working age, higher poverty rates, and a higher prevalence of mental health problems. One of the support measures in Belgium to encounter these potential barriers is the paid care leave." For care provided to dependent elderly, the focus on relatives of working age risks hiding the reality that the main carer is the partner who is no longer of working age and is sometimes already dependent.[17] While in home care settings we regularly observed that total professional care is equal to 8 hours per week, informal care remains at 40 hours per week. In a study on dependent persons receiving Flemish Care Insurance, informal care was estimated at some 38 hours, of which 32 hours by the main carer (Pacolet et al., 2010). Additional support for the main carer also becomes important if this is the spouse. This could be provided by professional care. The study also estimated the additional financial cost informal care implied for the dependent person. The total estimated additional non-covered costs of ± EUR 350 per month included an (underestimated) average cost of informal care of some EUR 32 per month (Ibid.). This is hardly in line with the substantial engagement in time.

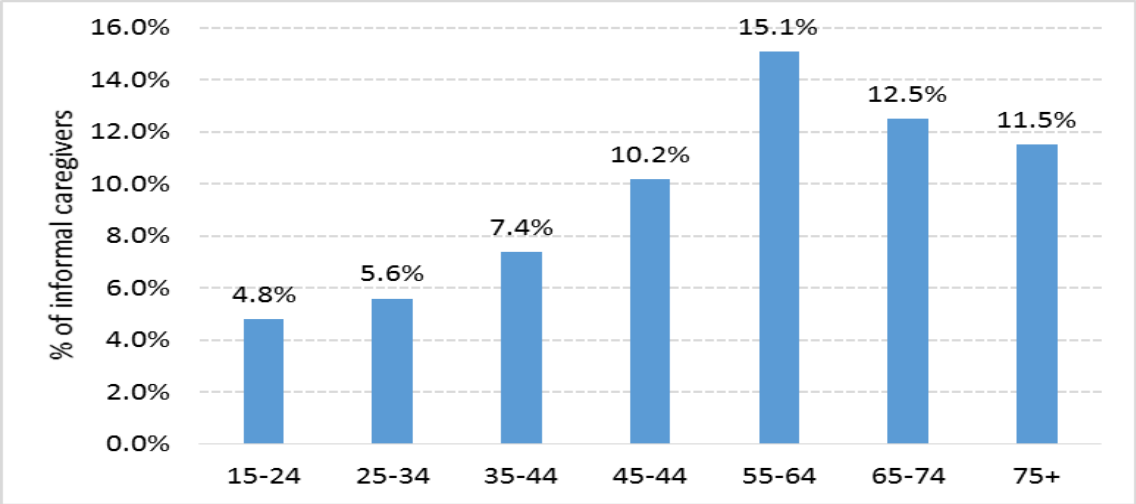
Figures suggest that it is particularly persons with a low income (quintile 1) who are providing informal help or care *(Figure 3)*. Questions on time spent[18] on informal care revealed that 2 out of 3 informal carers of working age spent less than 10 hours per week on the provision of informal care, 16% spent 10 to 19 hours per week and 17% spent more than 20 hours per week *(Figure 4)*. For those providing informal care, time spent on informal care does not increase significantly over the age groups. These results are similar to those reported for Belgium in a recent report published by Eurofound (2015) given that 16% of the Belgian working population state that they take part-time care of an older family member and only 2.9% take full-time care.

[16] See also http://statbel.fgov.be/nl/statistieken/cijfers/arbeid_leven/eu-silc/armoede/

[17] A survey on home care for dependent elderly revealed that the main carer was in 1 out of 2 cases the partner, and in 40% of cases (s)he was already older than 65 (Hedebouw et al., 1988). This profile is confirmed by the recent Belgian Health Interview Survey (Demarest, 2015) where the share of informal carers above 65 providing care more than 20 hours per week is the highest. But this survey also reveals that the hours of informal care provided by the age groups 55 to 64 years and even 45 to 54 years are of a similar level.

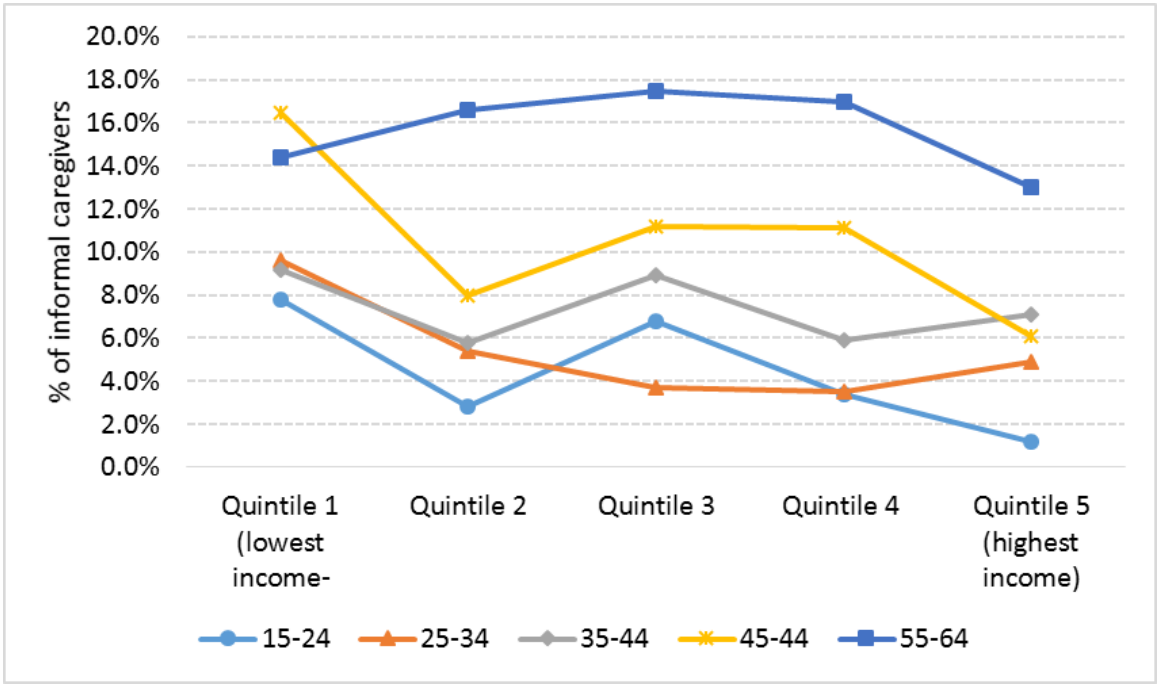
[18] An alternative source are the figures on the time-use of Belgian people http://www.time-use.be/en/statistics

Figure 2 Percentage of informal caregivers, breakdown by age, as % of total population aged 15 and older, Belgium, 2013



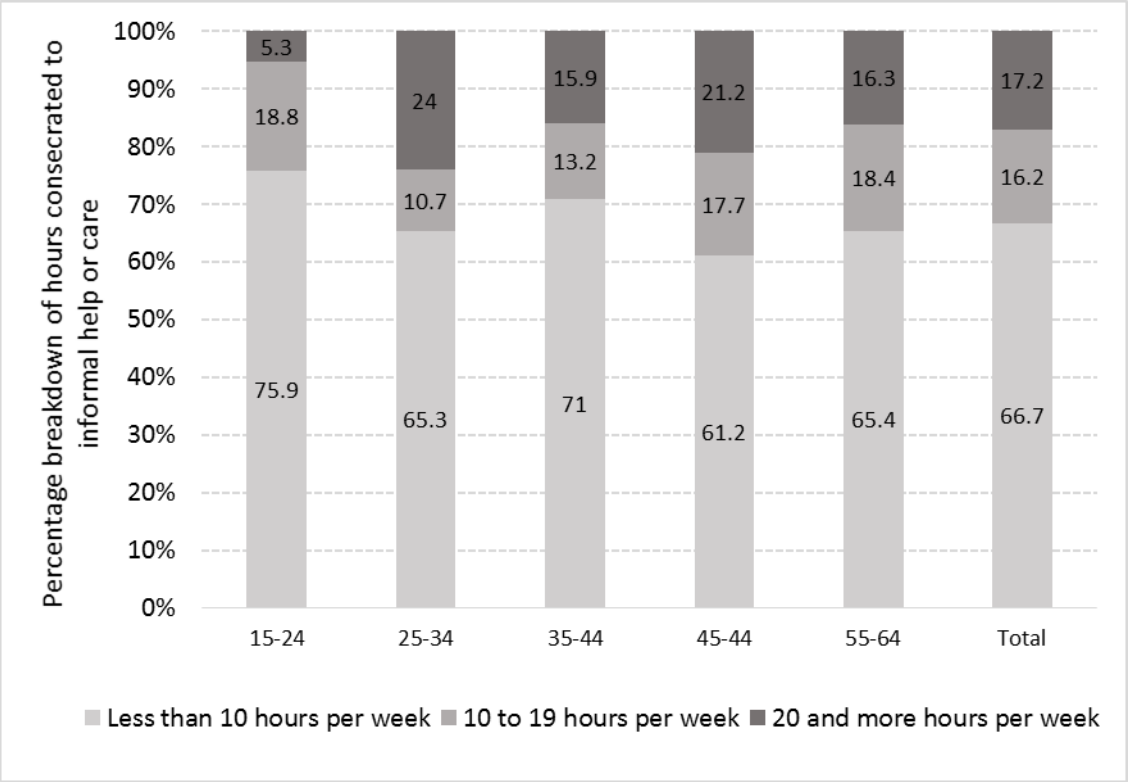
Source: *Belgian Health Interview Survey, 2013*

Figure 3 Percentage of informal caregivers, breakdown by age and income quintile of the informal caregivers of working age, Belgium, 2013



Source: Belgian Health Interview Survey, 2013

Figure 4 Percentage breakdown of hours consecrated to informal help or care, breakdown by age of the informal caregivers of working age, Belgium, 2013



Source: Belgian Health Interview Survey, 2013

2.3 Policy recommendations

Belgium already combines well-developed formal long-term care infrastructure and services with fully developed policies for the reconciliation of work and care.
There is much agreement on policy and the direction in which the long-term care system should evolve. The overall goal is to enable older people to remain at home as long as possible and to ensure their autonomy. Keeping more people at home also requires more attention to the recognition of and the support for informal carers *(mantelzorgers, aidants proches)*.[19] As remarked by the Federal Advisory Council for the Elderly (2015), this cannot replace the need for more formal long-term care infrastructure and services.

Moreover, a major challenge for Belgium is to combine a higher level of employment (in order to reach the EU 2020 target of an employment rate of 75%) with a relatively high informal level of care. Despite budgetary restraints, further development of both the long-term care benefits in kind and the carers' leaves is therefore essential in order to achieve a higher level of employment and a sustainable work-life balance for persons of working age with dependent relatives. In view of the ageing population, a growing share of informal care will be provided by the retired partner, sometimes already dependent themselves. The growing need for professional care to support the main carer will contribute to further job creation in the future.

[19] Certain components of the Law of 12 May 2014 'Wet betreffende de erkenning van de mantelzorger die een persoon met een grote zorgbehoefte bijstaat / Loi relative à la reconnaissance de l'aidant proche aidant une personne en situation de grande dépendance' have not yet been translated into a Royal Decree.

We conclude that more efforts to increase awareness and knowledge about the entitlement to carers' leaves and long-term care benefits in cash and in kind are still needed to avoid a low take-up rate. Granting carers' leaves or benefits automatically, as for instance the Flemish Care Insurance in some cases, would be even better.

The broad coverage and the long duration of most of the LTC benefits and carers' leaves are positive elements. Nonetheless, a higher replacement rate could avoid that informal carers show high losses in income and a high at-risk-of poverty rate.

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