ESPN Thematic Report on Challenges in long-term care

Belgium

2018

Jozef Pacolet & Frederic De Wispelaere
March 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

EUROPEAN COMMISSION

European Social Policy Network (ESPN)

ESPN Thematic Report on Challenges in long-term care

Belgium

2018

Jozef Pacolet & Frederic De Wispelaere

Directorate-General for Employment, Social Affairs and Inclusion

2018

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 the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

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

Contents

Summary

For decades Belgium has had a well-developed system of social protection covering the needs of dependent persons, such as the elderly and persons with disabilities or chronic diseases. This social protection scheme includes both cash and in-kind benefits, as well as some care allowances. The system is, however, multi-layered and sometimes hidden within health insurance; other provisions come under regional competencies for social services. The multi-layered system makes it difficult to assess the total level of public spending on long-term care (LTC).

The provisions for the elderly are for the most part distinct from those for disabled persons younger than 65, although there are initiatives to make the two systems more integrated.

From 2013 there was a substantial devolution of responsibilities for LTC from the federal level to the regions – including, from 2015, of residential care and the care allowance for the elderly (CAE). During a subsequent transition period the regions, at different speeds and in different directions, integrated these new competencies in existing or new institutions, and either started (in the case of Wallonia, Brussels, and the German-speaking community) or continued (Flanders) to develop an explicit system of LTC insurance. The latter already existed in Flanders, from 2001 on, as a limited (in terms of benefits) but visible and widely spread explicit LTC insurance scheme. It has become the basis for the actual devolution of new competencies in Flanders and has also inspired institutional reform in the other regions.

At the federal level the most important LTC service is now district nursing. Financing and regulation of in-kind and cash benefits are devolved to the regions, or so-called Communities. The most important residential care setting is the old-age home, with growing – but nevertheless insufficient – public financing. Average public financing in 2017 reached some EUR 54 per day per beneficiary in Belgium and some EUR 55 per day in Flanders. In Flanders the average co-payment by users was some EUR 54 per day, meaning that for the first time in decades it was lower than the average amount of public financing. But even then residential care remains unaffordable for many pensioners. In Flanders the LTC cash benefit of EUR 130 per month, and for the whole of Belgium the care allowance for the elderly of a maximum EUR 571 per month, helps to sustain affordability. The most important form of community care is home help and home care, financed by the regions and to a lesser extent (some 15 to 20% of the total cost) by the user.

In budgetary terms total public LTC spending is some 1.28% of GDP for in-kind benefits and some 0.16 % of GDP for cash benefits; the latter reaches 0.31% of GDP in Flanders with the additional care allowance under the LTC insurance scheme in place since 2001.

The voucher system for domestic work has also been transferred to the regions. This was originally meant as an employment policy, but became a substantial element in home help for the elderly. In macro-economic terms public support for this system for persons above 65 is also some 0.16% of GDP, topping up traditional LTC benefits by another 10%.

Although the use of residential or home care services is highly developed, both in depth and in breadth, there is a growing concern about its affordability for the user, the budgetary sustainability of some services, and also growing privatisation – in both community care and residential care settings.

On top of that, Belgium's well developed system of care leave has also recently been improved to support main carers who are of working age. This reminds us of the characteristic *par excellence* of community care, namely that care for the elderly is in the first place informal care. For Flanders/Belgium on several occasions it has been demonstrated that while professional care at home is on average some 8 hours per week, informal care is some 38 hours per week, or even more, mostly provided by one main carer, most of the time an older person themselves and in need of professional

support in carrying out care duties – illustrating that informal and formal care are complementary.

1 Description of the main features of the country's long-term care system(s)

For decades Belgium has had a well-developed system of social protection covering the needs of dependent persons, such as the elderly and persons with disabilities or chronic diseases. This social protection scheme includes cash and in-kind benefits, as well as some care allowances. This system is, however, multi-layered and sometimes hidden within health insurance. Other provisions come under regional competencies for social services. A major distinction needs to be made between long-term care (LTC) provision for mostly older persons, and the special provisions for disabled persons. This report is limited to the LTC for the elderly, but for reasons of transparency we have kept some references to certain benefits for disabled persons. Benefits providing replacement income are not mentioned, although in theory there can be a trade-off between for instance the level of pensions and the public financing of LTC.

The organisational landscape of LTC provision is fragmented because of the division of competencies between the federal government (responsible for medical care through the health care system) and the communities[1] (responsible for non-medical care). As in some other countries, LTC consists of a mix of different services and measures, funded through different sources and organised at different levels. In Appendix 1 we provide an overview of the most important systems that compose LTC, before and after the 6th State Reform.

The health insurance scheme (RIZIV-INAMI) now represents the bulk of LTC provision at the federal level. This includes in-kind benefits such as district nursing and physiotherapy. Those systems are financed by the health insurance scheme, itself financed by social contributions and from general government revenue. The patient has to make a limited co-payment for home nursing (although reinsured to a large extent by the sickness fund), and a co-payment for physiotherapy.

At regional level, home care, home help, residential care and certain care allowances are provided. There is a co-payment by users for housing and catering costs in residential care. Income-related co-payments are also there for home care and home help. The care allowance for the dependent elderly (CAE), previously a non-contributory scheme organised by the Ministry of Social Affairs, is now also devolved to regions. The CAE is differentiated according to the degree of dependency of the beneficiary, and according to income (including income from assets). The maximum amount is EUR 571 per month but can be lower when dependency is lower and income is higher.

In 2004 a new system of support for domestic help was created via so-called service vouchers, which the user can buy at a reduced cost (via substantial subsidies, exclusion of VAT and tax credit) to cover a certain number of hours of domestic work. It became a substantial alternative to the traditional home help, and perhaps even home care, services.

At federal level there is no specific legislation concerning LTC: rules concerning LTC services such as home nursing or old-age homes are to a large extent the same as

[1] The Flemish, French and German-speaking Communities are responsible for 'person-related matters', including some that affect health care and LTC. The Flemish and German-speaking Communities assume these responsibilities themselves, while the French-speaking Community has devolved its competence to the Walloon region. In Brussels, matters are arranged by three Community commissions - the French Community Commission (*Commission Communautaire française*, COCOF), the Joint Community Commission (*Commission Communautaire Commune*, COCOM) and the Flemish Community Commission (*Vlaamse Gemeenschapscommissie*, VGC).

under the general health care system while other systems were created for disabled persons or the dependent elderly.

At the regional or community level, separate decrees regulate a wide range of aspects concerning the provision of LTC services, such as the recognition of providers, integration of services and quality monitoring. Provision of (in particular) home help and home care is also situated at this level, but also several other residuary social services for the elderly such as 'meals on wheels', semi-institutional care settings, home adaptations, adapted housing and service flats.

Up until the 6th State Reform of 2014, LTC for the elderly was embedded in the health insurance scheme: mainly old-age homes, nursing homes and district nursing – a kind of implicit 'long-term care insurance' (Pacolet J. et al., 2000). Communities were responsible for home care and home help, some regulatory competencies, and part-financing of old-age and nursing homes. A wide range of community services for the elderly are in place, including home help or domestic help, home care, odd-job services, meal distribution, transport services, respite care, tele-alarms, and social work. The major and most time-consuming form of community care is home care and home help. It is financed by the regions but there is also an income-related co-payment. For instance, in Flanders the total cost of one hour of home care in 2011 was EUR 34, of which EUR 4.94 was covered by a contribution from the user (or 14.5% of the total cost). For home help it was respectively EUR 32 and EUR 6.22 or 19.4% of the total cost, illustrating that a less care-intensive service could allow a higher user co-payment (Pacolet J. et al., 2013, p. 237).

For disabled persons, up until the State Reforms of 1980 and 1988, replacement income, reintegration support and care were organised and financed at federal level as well. Since respectively 1980 and 1988, the latter two have been organised at the level of the communities. Since 2007 reintegration into the labour market has been part of mainstream employment policy in Flanders, while financing of care services remains the responsibility of the regional office for disabled persons (VAPH). In Wallonia and Brussels both responsibilities (integration in the labour market and care) remain within the same institution (respectively AWIPH and PHARE). The responsibility for the income replacement benefit for disabled persons, and for the integration allowance for disabled persons (*allocation d'intégration/integratietegemoetkoming*), remain at the federal level (Federal Public Service Social Security). The latter is comparable to the care allowance for older persons.

The federal government negotiations Di Rupo I (2010-2014) resulted in a 6th institutional reform of political competencies in Belgium, including a substantial shift in the competency for LTC insurance. This reform has been in force since 1 July 2014. The relevant responsibilities for LTC were transferred from 2015 onwards, along with budgetary responsibility. A transition period was foreseen for some administrative issues and there was also a freeze on new regulations to facilitate a controlled transfer of the competencies.

In Table 1 we provide a synoptic overview of the major LTC provisions. On top of in-kind and cash benefits, a set of provisions allows or stimulates informal care through care leave[2]. The regulation of this care leave and eventual allowance is provided by the federal unemployment insurance, sometimes topped up with regional allowances[3].

[2] See the ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives (De Wispelaere F. & Pacolet J., 2016).

[3] In Flanders, for instance, there is an additional allowance to support informal care, but even the combined federal and regional allowance hardly compensates for the loss of income for people stopping work or working less. For that reason, a trade union (ACV) has recently asked to increase of those allowances (Janssens, A., 2018)

Table 1 A non-exhaustive overview of cash benefits and benefits in-kind for LTC and care leave in Belgium

Benefits in-kind	Cash benefits	Care leave
Home care and home help	Child benefits: supplementary allowance for children with disabilities under the age of 21	Time credit leave with a specific reason
Medical home nursing care	Care allowance for the elderly *(CAE)*	Thematic leave: career break in the context of leave for care and help or for palliative care
Centres for day care and 'short-stay' care	Integration allowance *(IA)* for disabled persons	Palliative care for self-employed persons
Service flats	Flemish care insurance	
Residential old-age/nursing homes		
Service voucher scheme		

In October 2015, the Flemish government approved a plan to create the Flemish social protection system, which includes a timetable for the integration of new devolved federal responsibilities and a transition to the roll-out of the new system from 2018 on. In Flanders, the new competencies have been integrated into the 'Zorgfonds' (Care Fund) established in 2001 – a first step in a Flemish LTC insurance – which has been transformed into the Flemish social protection system (Conceptnota VSB, 2015). Beginning in 2018, the Flemish government accepted the decree relating to this Flemish social protection scheme. This scheme is a mandatory insurance system, based on solidarity, that will cover several parts of current benefits: Flemish care insurance for heavily dependent people (*Vlaamse Zorgverzekering*); a cash benefit to meet the basic needs of people with a disability (BOB – *Basisondersteuningsbudget*); the CAE; public financing of residential care for the elderly; the income-related co-payment in home care; and finally rehabilitation and technical devices for persons with a disability. It doesn't involve home nursing and psychiatric home care, which remain federal competences. In the context of the fiscal consolidation of the Flemish budget, the existing contribution for the Flemish care insurance scheme of EUR 25 per adult (> 25 years) per year has also been increased to EUR 50. At the beginning of 2018 the Flemish government started a campaign to raise awareness of the fact that this contribution implies solidarity with dependent persons[4]. The cash benefit of the original Flemish care insurance is EUR 130 per month; only those people living at home with relatively high dependency are eligible, while all persons in an old-age home are eligible.

In January 2018 the Flemish government approved the decree on the Flemish social protection scheme, which includes the previous Flemish LTC insurance, the devolved CAE, and the newly created BOB for disabled persons. From 2019 on, residential care for the elderly, home care and some other related services will be integrated in the system. In the near future it will include a budget of some EUR 4 billion. For dependent people and the elderly, a further harmonisation has been announced by using a personal care voucher (*zorgticket*) (Agentschap Zorg en Gezondheid, 2018).

[4] http://www.vlaamsesocialebescherming.be/.

A substantial part of the reform consists of the transfer of responsibilities for residential care from the federal health insurance system to the regions. During a transition period the financing mechanisms will remain the same (Vlaamse Regering 2014, , p. 116). In the future, the intention is to convert the current financial system (financing the supply side) into a personal budget system (financing the demand side) that will probably take the form of a voucher system or 'care ticket'[5]. The existing Flemish public financing of the infrastructure (some 60% of total cost of the infrastructure) of the non-profit sector, has been converted since 2016 into a lump-sum allowance for housing costs, open to all (for-profit and not-for-profit) providers. In December 2017 the Flemish Minister for health, social care and family, J. Vandeurzen, launched a concept note that outlines future policy measures for residential care for the elderly: enlarged capacity based on new planning figures; improved financing, including readjustments of the dependency categories used[6]; and improved monitoring and control of user contributions. In this context it will be discussed with stakeholders whether a standstill of those contributions could be guaranteed for existing users from the moment they enter the institution (J. Vandeurzen, 2017).

As from 1 January 2017, the CAE is also part of the Flemish social protection system. Since that date, in Flanders, the care funds of the sickness funds or the public centres for social welfare handle the demand for CAE. In Brussels and Wallonia, the Federal Public Service of Social Security will remain responsible for it until the planned LTC insurance is operational there (Federale Overheidsdienst Sociale Zekerheid, 2017).

In the Walloon region, the 6th State Reform implies that the competency for this policy is no longer fulfilled by the *Fédération Wallonie-Bruxelles*, but the Walloon region itself. In the governmental declaration of the previous government (*Gouvernement Wallon*, 2014), continuity was guaranteed, but changes were also announced. Hence, the intention was to maintain the conditions for the CAE, but in the future more priority would be given to in-kind support as a response to real needs instead of a system of additional income support. Home care would become more affordable by indexing the income thresholds that determine co-payments. In residential care, not only is continuity guaranteed by the agreements with the national health insurance scheme and by continued support for new infrastructure, but a shift toward more 'transmural' services has also been announced. It illustrates how in the future devolution could result in further differences in policies.

In July 2015 the Walloon government announced the creation of a 'Walloon agency for health, social protection, disability and family' (*Agence wallonne de la Santé, de la protection sociale, du handicap et des familles*) from 2016 on. It was to be organised around three pillars: health and social care, disability, and family policies. The new organisation was launched from 1 January 2016 under a new name: *AVIQ Agence pour une Vie de Qualité*. In addition, an LTC insurance scheme (*assurance autonomie Wallonne*) will be created to reinforce support for dependent persons, starting from 2017. It is organised in a way similar to the original Flemish care insurance scheme, i.e. in cooperation with the sickness funds who will play an important role and it will be financed with a similar contribution of EUR 50/person/year. Contrary to the Flemish scheme, the Walloon insurance scheme will focus only on home care and in-kind care; but many reacted by suggesting that the residential care sector also needs a similar initiative (Parliamentary Question Alain Onkelinx to Minister M. Prévot, *Parlement de Wallonie*, 2016).

In June 2017 a general political crisis emerged in the Walloon government and a new government was installed. In November 2017 the new government's plans for LTC insurance (*assurance autonomie*) became clear. Within AVIQ a two-pillar system will

[5] See the acceptance of the decree on the Flemish social protection by the Flemish government in January 2018.

[6] A Katz-scale of dependency is used in old-age homes (*ROB rustoordbed*) and nursing homes (*RVT – rust- en verzorgingstehuis*) to assess the dependency for ADL and IADL (activities of daily living and instrumental activities of daily living).

be created, which consists of (on the one hand) in-kind services for a certain number of hours of home care and home help, and (on the other hand) the continuation of the CAE. As in Flanders, the sickness funds will also take up a role in the organisation of LTC insurance. In-kind support will take the form of a 'long-term care account', expressed in number of hours, opened in the LTC fund of the sickness fund. The insurance will also be partly financed, again as in Flanders, through a yearly contribution by each person above 26 years old of EUR 50, EUR 25 for the lower-income group.

In the Brussels region, the governmental agreement of the Common Community Commission stipulates how LTC competencies for the Brussels region will be organised. A study has been conducted into an LTC insurance scheme similar to those in the other regions. One specific idea was to transform the selective allowance for dependent elderly people into a universal insurance for all (De Brouwer H. et al., 2016). This study seems not to have been conclusive, since new studies were launched in January 2018. The Brussels regional government is also now responsible for residential care, and in May 2016 it announced a moratorium on new places in old-age homes: there were more than 2,600 vacant places, illustrating an urgent need to adjust the supply of residential care in Brussels in response to the trend towards de-institutionalisation.

Belgium already combines a well developed formal LTC infrastructure and services with a fully developed policy regime for the reconciliation of work and care. In the ESPN thematic report on LTC and work-life balance it was confirmed that the wide scope of professional services for the elderly and dependent persons supports informal carers and enables them to combine care responsibilities with working life. Financial affordability in the future will be improved by means of cash allowances. A well developed system of care leave also exists (De Wispelaere F. & Pacolet J., 2016). At the end of 2016, the federal government approved a new law on workable and flexible work (*wet werkbaar en wendbaar werk*), which includes regulations to encourage the provision of care leave. From February 2017, palliative care leave was extended from 2 to 3 months (1 month + 2 possible extensions). The maximum duration of time credit (see De Wispelaere F. & Pacolet J., 2016) was also extended from 36 or 48 months to 51 months (Group S, Human Resources Management Solutions, 10-01-2017).

Informal care is the characteristic form of care for dependent elderly people in the home. As long ago as 1985 a study concluded that all types of professional care added together averaged 8 hours per week per person cared for, while informal care was some 40 hours a week or even more, most of the timeprovided by the main carer, often the spouse or a child. For persons with dementia, situations were observed of more than 80 hours of care a week, if not '24/7' availability and support (Pacolet J. et al. (eds), 2001). Long-term elderly care is first of all informal care. Those figures were confirmed by a recent survey of formal and informal care and related costs for persons benefiting from the Flemish care insurance scheme at home, some 175 000 persons (see Appendix 2). The average informal care they received was again some 38 hours per week, of which some 21 hours per week were so-called 'hard care' – housekeeping, personal care, help with mobility, shopping, etc. The rest was so-called 'soft care' – supervision, company. Differentiated by three dependency categories – mild, more severe and very severe – the total informal care needed was 30, 45 and 32 hours a week respectively. For the very severely dependent, informal care was probably substituted by professional care[7]. The 'hard care' time was more stable, at 19, 21 and 19 hours per week respectively: some standard time of some 3 hours a day, needed for the main tasks. Informal care tends to be concentrated on one 'main carer': of the above-mentioned average of 38 hours, 32 was provided by the first main carer and 6 by a second carer (Pacolet J. et al., 2010, pp. 98, 165-168).

[7] This evidence lends supports to the mechanism in the Luxembourg LTC insurance system whereby the cash benefit that supports informal care is capped at a certain level, implying that beyond that level care needs to come from a professional carer. See Pacolet J. & De Wispelaere F., 2018.

In Table 2 we give a non-exhaustive overview of public expenditure on LTC in Flanders and in Belgium, in EUR million and as a percentage of the regional or national GDP, to illustrate their relative importance. Spending on in-kind benefits for disabled persons is also included, since that seems to be as important as residential care for the elderly. The major areas of spending are residential care and home care (the latter by the way not completely oriented to the elderly), care infrastructure and geriatric services. In total, it was equivalent to some 0.95% of GDP in Flanders in 2014. To this needs to be added home nursing, or so-called district nursing – at federal level equivalent to some 0.34% of GDP: but this is part of the health insurance system, as well as physiotherapy. Excluding the latter two, the traditional major in-kind LTC benefits are some 1.28% of GDP. The CAE cash benefit and the Flemish care insurance are together equivalent to some 0.31% of GDP. The total for all these LTC benefits, in kind and cash, comes to 1.59% of GDP. In addition there is the share of public spending on service vouchers for those aged 65+, estimated at some 0.16% of GDP, which adds about 10% to spending on the more traditional LTC services.

Table 2 Some major categories of public financing of LTC for the elderly in Flanders and Belgium, in EUR million and % of GDP

Benefit	In EUR million, public expenditure, 2014	As % of regional or national GDP
Flanders		
Residential elderly care (a)	1 497	0.64
Care for persons with disability (b)	1 426	0.61
Service vouchers (c)	1 062	0.45
Home care (d)	623	0.27
Care allowance for dependent older persons (e)	387	0.16
Care infrastructure (f)	200	0.09
Fiscal expenditures service voucher (g)	198	0.08
Flemish care insurance (cash benefit) (h)	336	0.14
Geriatric services (i)	102	0.04
LTC for the elderly (in kind) in Flanders (j=a+d+i)	2 222	0.95
LTC for the elderly (cash) in Flanders (h=e+h)	723	0.31
Service vouchers for 65+ (k=30% of total c+g)	378	0.16
LTC for the elderly in Flanders, including home nursing (total in kind) (o=j+l)		1.28
Total LTC spending in Flanders (p=o+h)		1.59
Belgium		
Home nursing Belgium, 2015 (l)	1 370	0.34
Physiotherapy Belgium, 2015 (m)	708	0.17
LTC in health insurance (n=l=m)		0.51

Source: Own calculation on Appendix 5 and budget RIZIV

Each year the Belgian Ageing Commission (Studiecommissie Vergrijzing) provides scenarios for the future impact of ageing on public spending, including for LTC. Those estimates are parallel to the Ageing Report 2015 of the European Ageing Working Group (AWG). But discrepancies occurred in the 2015 wave because of differences in demographic assumptions (the Ageing Report 2015 assumed that the Belgian

population would increase to 15.4 million by 2060 while the national demographic hypothesis was 13.1 million (Studiecommissie Vergrijzing, 2015)[8]); and also because of the exclusion of the most recent pension reforms in the European scenarios. Furthermore, the use of a different definition of LTC complicates the comparison between the reports and leads to different levels of spending on LTC. In the AWG Report 2015 total public spending on LTC in 2013 was estimated at some 2.1% of GDP, rising to 3.7% of GDP by 2060. In the most recent national ageing report (Studiecommissie Vergrijzing, 2017, p.6) LTC spending was put at some 1.6% of GDP in 2016, rising to 2.5% of GDP by 2060. The differences are explained by a larger share of LTC expenditure included in the national definition of health care, despite the fact that the European definition does not include some LTC expenditure on disabled persons. So whereas public health care expenditure rises from 6.0% of GDP in 2013 to 6.1% in the AWG Ageing Report 2015, the national ageing report mentions an increase for health care from 6.4% of GDP to 7.6%. A recent study of the impact of different demographic scenarios (Duyck J. et al., 2018) reveals that assuming a higher mortality rate (a life expectacy in 2060 at birth for both men and women 2.5 years lower that in the reference scenario) would reduce the increase in LTC spending between 2017 and 2060 by 0.5 percentage point of GDP, and by 0.1 percentage point of GDP in the case of health care, illustrating the relative limited cost of longevity. The recent European Semester Report for Belgium revealed also the evolution in LTC expenditure according to the Ageing Report 2018. Between 2016 and 2070 public spending on LTC would evolve from 2.3% of GDP in 2016 to 4% in 2070. This is not so much more than the projections in the 2015 Ageing report, and is already influenced by a downward revision of the demographic projections of the total population from 15.4 million to 13.6 million, bringing the European demographic projections into line with the Belgian ones.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

In this section we assess the major challenges with which the LTC is confronted, in terms of improving the access and adequacy, quality and sustainability of the LTC system(s), how present reforms are responding to it and what policy recommendations can be made.

2.1 Challenges in LTC

The 6th State Reform was approved in 2013. The transfer of operational/administrative responsibilities started in 2014, at different speeds as agreed in transition protocols and were integrated in existing regional or still to be defined new regional institutions. In Appendix 1 we give an overview of the architecture of the devolved LTC insurance scheme for the elderly as it is under construction. The complexity is not even completely reflected in this overview since we do not go into detail on the situation of persons with a disability or many other less important LTC provisions. The transition period will cause some temporary confusion about how the system will be organised. Nevertheless, despite the risk of divergence raised by devolution, the results seem to confirm previous characteristics, namely: the priority for in-kind benefits; the maintenance of cash allowances; the ambition to install in all regions an explicit LTC insurance scheme; and the preference for maintaining and even reinforcing the role of sickness funds in the new LTC insurance system.

In home care services there has been a growing concern about the service voucher system and its growing budgetary cost. The introduction of the voucher system in 2004 allowed the provision of services such as domestic work, cleaning, and ironing, but also basic tasks such as running household errands. The public subsidy is

[8] In the Ageing Report 2018 the European scenario will use for 2060 the number of 13.6 million, in line with the national hypothesis.

substantial, including the direct subsidy, an income tax credit and exemption from VAT. In Flanders no fewer than 194 555 persons older than 65 use the service. Elderly people receiving a care allowance can buy 2 000 hours of care per year[9] and the tax credit is reimbursable for those not paying taxes (which applies to many retired persons). Because of this substantial element of public financing, it is no wonder that as well as the dominant commercial providers, the traditional non-profit and public home care providers are also very active under this new scheme. In Appendix 3 we see how in Flanders, for instance, a good five years after its launch in 2004, the voucher system has crowded out or topped up the traditional home care and home help services, the latter with a history going back decades. Traditional home care and home help activities accounted for some 23.2 million hours, while the new commercial providers were delivering domestic help of some 20.2 million hours under the voucher scheme. But traditional providers had also penetrated the market for vouchers, supplying 18.4 million hours of care under it and enlarging their traditional supply (Pacolet J. et al., 2011).

Residential services for the elderly have also been devolved to the regions, along with associated financing and price regulation responsibilities. The same goes for the CAE. But the care allowance for disabled persons remains federal and the same goes for district nursing, although it is close in nature to community care and home help. The service voucher scheme for domestic services, which is part of employment policies, is also being decentralised. The further expansion of those newly devolved systems has become a regional responsibility. Keeping in mind that demand for LTC services is mostly driven by the ageing of the population, this shift in responsibilities will have both immediate and long-term implications. The search for savings in the federal budget will in turn result in pressure on local authority finances, which implies a risk that the subsidies to those services will be reduced; or that local authorities may withdraw as providers of LTC services such as home care or residential care for the elderly.

Budgetary restrictions mean that regions are faced with a choice between expanding traditional home care and home help services, or leaving that to be covered by the voucher system and instead maintaining care allowances. Flanders seems up until now to have been able to maintain the best of both worlds. In Wallonia, on the other hand, there is already some restriction on the use of the service voucher system and consideration is being given to whether or not part of the care allowance budget could be used for financing home care services: however, the latest proposals in Wallonia point towards the care allowance budget being maintained.

There is also a growing concern about privatisation of the LTC sector. We have already given the example of the enormous expansion of the newly created service voucher system, which as a kind of ‘tsunami’ overflows the traditional home care and help sector, especially with the supply of commercial providers. In the residential care sector there is also a growing concern about the growing market share of commercial providers. Recent information on the ownership structure is provided in Appendix 6. Although for the most part the public or private non-profit sector plays the major role, for example in Flanders, the commercial sector is more important in Wallonia and even more so in Brussels. In Wallonia this has led to a cap being placed on the for-profit share of provision, although abolition of the cap is currently under discussion. There is also in Flanders, however, a growing trend towards privatisation, which is not always visible in the statistics. This because most statistics are based on legal ownership structure, which disguises the fact that some private non-profit institutions (‘*vzw*’) are part of a commercial group – what might be called a ‘bogus non-profit’ institution. More recently the Flemish administration has identified no fewer than 100 bogus non-profit old-age homes to be added to the 135 commercial old-age homes. That ownership matters is illustrated by the fact that the average day price for the elderly of those commercial initiatives increases from EUR 59.87 to EUR 61.96 when those bogus firms are included (*Agentschap Zorg en Gezondheid*, 2018). This illustrates that

[9] Also for single-parent families and for disabled persons or persons with a disabled child.

those bogus non-profit organisations are even more expensive for the elderly than the other commercial firms.

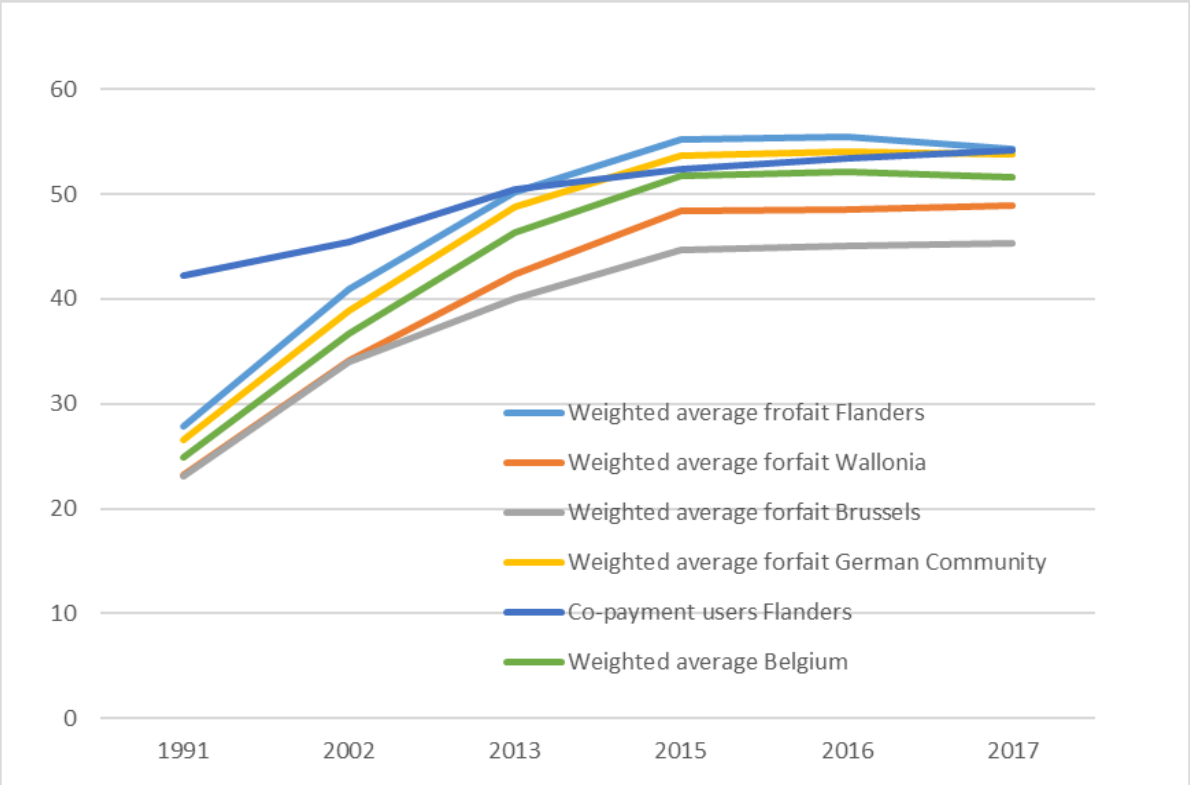
The concern about privatisation was also present in the *'Plan Papy Boom'* launched by the Walloon Minister of Health, Maxime Prévot, in May 2017. The plan was aimed at reforming the regulation and financing of residential care for the elderly (old-age homes and nursing homes for the elderly – *maisons de repos* and *maisons de repos et de soins*). It included a new public financing mechanism (starting in 2019) for infrastructure as well as personnel costs, including a catching-up plan to increase the number of residential places in the short time, introduction of quality standards but a levelling of the playing field for all providers – with some priority, however, for public and non-profit providers (M. Prévot, 2017).

Studies have regularly provided evidence about the risk that co-payment in residential care, since it is not related to income, may become unaffordable for the elderly with a low income. In a recent report by the Socialist Sickness Fund (Solidaris – *Socialistische Mutualiteit*) the average monthly cost of co-payment and other supplements of EUR 1 595 compares with an average pension for a worker living alone of EUR 1 075, and for a woman of only EUR 776 per month (quoted in Pacolet J. et al., 2018). The affordability of residential care is supported in the whole country by the CAE. It is related to dependency but also income, and to a certain degree also wealth since a certain return on financial assets is assumed and added to income. The value of the person's house is not taken into account. In Flanders the additional Flemish LTC allowance is related to neither income nor dependency since all persons staying in an old-age home can benefit from it. Van den Bosch (2016) illustrates that when the user payment is high (e.g. when persons are less dependent) there will be a lower public payment and a lower care allowance, so that there can be a problem of affordability in those cases. A report on the financing of residential care observed that public financing compared with government norms in Flanders was especially low for the lower-dependency categories (Pacolet J. & De Coninck A., 2015).

2.2 Planned reforms and how they address the challenges

The most important contribution to the affordability of LTC is the level of direct public financing and the control of co-payments by the elderly. Not only is there a difference in the level of dependency found in different regions, but this is also the basis for differences in public financing by the health insurance system. It is low (too low) for the low-dependency category, but it is higher and better reimbursed through the nursing home tariff for the more dependent categories. But even then there is underfinancing. Nevertheless over time, because of the shift of beneficiaries to more dependent categories with better financing, the total average public support has increased substantially in all regions. In Graph 1 we give for all regions the average public financing in euros per day. It is the highest in Flanders, the lowest in Brussels. This is certainly influenced by the higher share of the low-dependency categories (O/A), probably the result of earlier entrance to old-age homes in Wallonia, and especially in Brussels. The high prevalence of residential care in the Brussels region, and probably also for Wallonia, can be understood by reference to family structure. In Brussels, and to a lesser degree in Wallonia, more people above 65 live alone, which can trigger institutionalisation. In Brussels, for instance, the average age in residential care is two years less than in the other regions. Entering two years earlier, given that the average length of stay is only two years, can have a substantial influence on the total level of prevalence of institutional care: in the Brussels region some 7.8% of persons above 65 live in an old-age home, while it is only 5.4% in Flanders (see Appendix 4).

Graph 1 Comparison of public financing and co-payments for users, in real terms, in euros per day, 1991-2017



Source: *See also Pacolet J. et al., (2018).*

The share of more dependent persons has increased: but so has related public financing, in particular for the most highly dependent persons. Although it remains insufficient, it has helped to moderate the real-terms increase in co-payments for users (at least in Flanders, as the graph shows). But in recent years there has been an acceleration in costs. In real terms (2015 prices) the average public financing for an old-age home in Belgium increased from EUR 25 per day per beneficiary in 1991 to EUR 52 in 2017. The average contribution by the elderly increased, for instance in Flanders, from EUR 42 per day to EUR 54. In Flanders public financing of some EUR 55 per day per beneficiary has become somewhat higher than the average co-payment by users.

A recent study argued that the regime of price declaration and price control in Flanders should be maintained and even reinforced (Pacolet J. et al., 2018). The Flemish government is planning to do so. In Flanders a new system of price declaration/registration has been in use since 2016, and prices per individual institution and per municipality are published. This increases to a large extent the transparency for the user, and perhaps also contributes to greater competition to keep those prices at a reasonable level. The existing system of price control is also being maintained in other regions.

The adequacy of human resources for health and social care has been a concern for decades. Several measures have been taken. To improve the attractiveness of wages in LTC services they have been aligned with those in the health sector. To improve the employment rate for older workers in both the health and social care sectors, a system has been introduced of reduced weekly working time from 38 hours to 36 from the age of 45, from 36 to 34 from age 50 and from 34 to 32 from age 55. Since the system was introduced, the average exit age has increased, adding further to its costs

and therefore the financing challenge of the LTC sector. Proposals have been made to either restrict it or to make it available at an earlier stage in the career (in the latter case making work in the LTC sector more attractive for younger persons). To improve the attractiveness of the profession and guarantee an adequate inflow from new graduates, several programmes have been launched to increase the interest of youngsters in an education in the care or nursing professions, or for already active persons and unemployed persons to obtain an additional diploma in those professions.

2.3 Policy recommendations

There is much agreement on the direction in which the LTC system should evolve and on the policies to achieve this. 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 support for, informal carers *(mantelzorgers, aidants proches)*. As remarked by the Federal Advisory Council for the Elderly in 2015, this cannot replace the need for more formal LTC 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, a further development of both in-kind LTC benefits and carer's leave 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 retired partners, sometimes already dependent themselves. The growing need for professional care to support the main carer will contribute to more job creation in the future.

More efforts to increase awareness and knowledge about entitlement to carer's leave and LTC benefits (both cash and in kind) are still needed in order to avoid a low take-up rate. The automatic award of care leave or benefits (see for instance the Flemish care insurance in some cases) would be even better.

The broad coverage and the long duration of most LTC benefits and care leave are positive elements. Nonetheless, a higher income-replacement rate could prevent informal carers incurring high losses in income and a high risk of poverty.

3 Analysis of the indicators available in the country for measuring long-term care

The ongoing devolution of responsibilities from federal to regional levels makes it harder to assess the level of provision, its financing structure, the outcome of the benefits, and the performance of the providers of services.

The opacity is added to by the diversity of the benefits provided, and the institutions that are responsible for them. It is an indication of a high level of development of the welfare state in general and LTC more specifically. At the same time LTC has only recently, despite its long tradition, been recognised as responding to a new social risk – whereas previously it was (not surprisingly) embedded in health insurance or other social services.

Even when standardised registration systems exist, in the form of the system of health accounts (SHA), LTC is for the moment not correctly included in those statistics, failing to include properly co-payments by users.

The multiplicity of financing mechanisms also makes the transparency of the accounts problematic. This is sometimes because institutions do not all have to follow the same accounting principles (e.g. the public sector compared with the private sector); sometimes because the accounts do not provide the information needed to assess performance correctly (for instance cross subsidisation or profit transfer to the real owners of the providers); and sometimes because legal form is not identical to real

economic ownership. This makes it difficult to assess correctly whether ownership matters, or what exactly are the real costs and profit margins in those activities.

The sector is increasingly publicly financed, and is confronted with both an increasing number of users and increasing levels of dependency. That will be the case for decades in the future. For that reason the Flemish government, for instance, has decided to maintain and reinforce its efforts to control the cost structure and price setting mechanisms in residential care for the elderly. But on top of that they have also started to provide more transparency by publishing yearly the charge to users in each residential care institution[10]. These efforts contribute to transparency not only for the regulator but also for stakeholders, and especially for the elderly themselves and their main carers.

The same approach to publicity and transparency has been pursued in relation to the assessment of care quality in old-age homes by the elderly themselves[11]. Since the early 2000s both home care providers and residential care services in Flanders have been subject to quality regulation in their sector, controlled by the Flemish care inspection of the Flemish social care, health and family administration (*Administratie Welzijn, Volksgezondheid en Gezin*) and the Flemish care and health agency (*Agentschap Zorg en Gezondheid*). For residential care, a project is currently running looking at objective indicators (such as the quality of care, and safety levels) and subjective indicators (such as the quality of life as perceived by the beneficiaries). The latter indicators have been constructed on the basis of a survey of beneficiaries or their proxies. The reports and results are published on the website of the administration for each individual institution. Sometimes the newspapers and other media give this kind of information further publicity[12].

[10] https://www.zorg-en-gezondheid.be/dagprijzen.

[11] https://www.zorg-en-gezondheid.be/resultaten-van-de-bevraging-in-woonzorgcentra-over-de-kwaliteit-van-leven.

[12] For instance, the user's charge in each individual elderly home was published by the Flemish government end of January 2018, and was later also a special item in the financial newspaper De Tijd: https://multimedia.tijd.be/woonzorgcentra17/.

Appendix 1

Architecture (under construction) of devolved long-term care insurance in Belgium, before and after the 6th State Reform and in the future, situation as known beginning 2018

Architecture (under construction) of devolved LTC insurance in Belgium				
Before 6th State Reform				
At federal level				
Home nursing	Federal health insurance			
Residential care for the elderly	Federal health insurance			
Service vouchers	Unemployment insurance and tax rebate			
Integration allowance for disabled persons	Ministry of social affairs			
Care allowance for the elderly (CAE)	Ministry of social affairs			
Price control of residential care	Ministry of economic affairs			
After the 6th State Reform				
At federal level				
Home nursing	Federal health insurance			
Physiotherapy	Federal health insurance			
Service vouchers	Unemployment insurance and tax rebate			
Integration allowance for disabled persons	Federal ministry of social affairs			
Regions				
	Flanders	Wallonia	Brussels region	German-speaking community
Devolved competencies				
Residential care for the elderly	VAZG from 2019 in VSB	AVIQ from 2019 on	Administration GGC and VAZG	Administration
Care allowance for the elderly	VSB	Assurance autonomie under construction	LTC under discussion	
Price control of residential care	Administration	Administration	Administration	Administration
Service vouchers	Administration work	Administration work	Administration work	Administration work

Other already existing competencies				
Care for disabled persons	VAPH	AViQ	Phare	Dienststelle für Selbstbestimmtes Leben
Newly created BOB	VSB			
Long-term care insurance	Zorgkas now VSB	Assurance autonomie under construction	LTC under discussion	LTC under discussion
Infrastructure care institutions	VIPA			
Home care	VAZG from 2019 on in VSB	AVIQ from 2019 on	Administration	Ministerium der deutschsprachigen gemeinschaft

Abbreviations: VIPA = Vlaams Infrastructuurfond voor persoonsgebonden aangelegenheden; BOB = Basis ondersteuningsbudget; VAZG = Vlaams Agentschap Zorg en Gezondheid; AVIQ = l'Agence Walone pour une vie de qualité; Phare = Personne handicapée autonomie recherchée; VSB = Vlaamse Sociale Bescherming; GGC = Gemeenschappelijke Gemeenschapcommissie.
Source: Own synthesis

Appendix 2

Number of users of residential care, district nursing and some other ambulatory health care services, Belgium and the regions, 2015

	Number of beneficiaries older than 65			
	At home	In residential care	Total	Year
	Flanders			
Home nursing	106 574			2015
Residential care		79 000		2017
Service vouchers, including fiscal rebate	194 555			2016
Home care and help				
Care allowance for the elderly	79 683	24 722	104 405	2017
Flemish care insurance (total)	175 502	78 312	253 814	2016
	Wallonia			
Home nursing	43 130			2015
Residential care		41 199		2015
Service vouchers, including fiscal rebate	81 701			2013
Home care				
Care allowance for the elderly			39 620	2014
	Brussels			
Home nursing	5 925			2015
Residential care		11 850		2015
Service vouchers, including fiscal rebate	21 007			2013
Home care and help				
Care allowance for the elderly			7 616	2014
	Belgium			
Home nursing	154 909			2015
Residential care		121 861		2015
Service vouchers, including fiscal rebate	265 692			2013
Home care and help				
Care allowance for the elderly			154 482	2014

Source: IMA, Gerard M. et al. (2014), Conceptnota.

Appendix 3

Crowding out or topping up of traditional home care and home help with voucher system, around 2009, Flanders, in millions of hours per year

	Voucher cheque			Traditional home care and help			
	Total	For 65+	For disabled persons	Home care	Home help	Other help	Total
Commercial providers	39.8	17.4	2.8				
Non-profit (private and public)	18.4			15	7	1.4	23.4
Total (including rest category)	59.6			15	7	1.4	23.4

Source: Pacolet J., De Wispelaere F. & De Coninck A. (2011)

Appendix 4

Profile of residential care, home nursing and some related benefits in Belgium and the regions, 2015 or latest information

	Estimated number of users, based on prevalence of use between 28/03 and 03/04 2015						
	Number of persons above 65	Number of 65+ living alone	**65+ staying in old-age homes**	**No district nursing or other related services**	**District nursing**	Total other temporary services	**65+ staying in hospital**
Brussels region	151 923	65 327	11 850	133 996	5 925	156	3 351
Flanders	1 268 740	365 397	68 512	1 088 579	106 574	4 238	23 979
Wallonia	643 732	214 363	41 199	558 116	43 130	927	12 353
Belgium	2 065 448	644 420	121 861	1 782 482	154 909	5 350	39 760
	Prevalence of users between 28/03 and 03/04 of 2015						
	% of 65+ of total population	Number of 65+ living alone	**65+ staying in old age homes**	**No district nursing or other related services**	**District nursing**	Total other temporary services	**65+ staying in hospital**
Brussels region	13.7%	43.0%	7.8%	88.2%	3.9%	0.10%	2.2%
Flanders	19.6%	28.8%	5.4%	85.8%	8.4%	0.33%	1.9%
Wallonia	18.3%	33.3%	6.4%	86.7%	6.7%	0.14%	1.9%
Belgium	18.6%	31.2%	5.9%	86.3%	7.5%	0.26%	1.9%
	Age and % of chronic diseases						
	Average age in residential care			% of age group with chronic diseases		% of age group with dependency for chronic reasons	
	Total	**Men**	**Women**	**65-74**	**75+**	**65-74**	**75+**
Brussels region	86	82	87	22.0%	39.2%	7.5%	14.2%
Flanders	86	84	87	19.7%	40.8%	7.6%	19.2%
Wallonia	85	82	86	24.2%	44.0%	8.3%	16.9%
Belgium	86	83	87	21.4%	41.7%	7.8%	18.1%

	Dependency degree of users total old age homes and nursing homes				
	Forfait O/A	**Forfait B**	**Forfait C**	**Forfait D**	
Brussels region	36.9%	23.3%	37.9%	1.8%	
Flanders	21.0%	30.0%	45.8%	3.2%	
Wallonia	31.2%	25.6%	41.1%	2.1%	
Belgium	26.0%	27.8%	43.5%	2.6%	

Source: Own calculations on IMA- AIM, Atlas data. Calculations are based on published prevalence figures, so figure for Belgium is not exactly the sum of the regions.

Appendix 5

Relative impact of devolution on the budget of the regions: the case for Flanders, 2014

Budget	in EUR million, public expenditure	as % of total budget	as % of regional GDP
Family benefits	3 557	9.6	1.5
Residential home care	1 497	4.0	0.6
Care for persons with disability	1 426	3.9	0.6
Service vouchers	1 062	2.9	0.5
Home care	623	1.7	0.3
Child care	568	1.5	0.2
Care allowance for the elderly	387	1.0	0.2
Youth care	377	1.0	0.2
Care infrastructure	200	0.5	0.1
Fiscal expenditures service voucher	198	0.5	0.1
Flemish care insurance (total expenditures)	336	0.3	0.1
Geriatric services	102	0.3	0.0
Total budget Flemish government	37 027	100.0	15.8
Total previous budget for LTC (without disabled persons)	1 050	2.8	0.4
Total budget devolved responsibilities in direct LTC for the elderly, without service vouchers	1 884	5.1	0.8
Total other devolved responsibilities	6 701	18.1	2.9
GDP	234 547		100.0

Source: Begroting Vlaamse Regering en Vlaams Zorgfonds.

Appendix 6

Evolution of the total number of beds in old age and nursing homes, Belgium, division by ownership and region (years 1996-2001-2007-2013-2016)

	1996		2001		2007		2013		2016	
	# beds	Share	# beds	Share	# beds	Share	# beds	Share	# beds	Share
Belgium	**106 525**		**122 792**		**126 467**		**134 748**		**143 761**	
Public share	37 855	36%	40 324	33%	40 360	32%	41 320	31%	42 298	29%
Private non-profit share	36 805	35%	41 479	34%	43 491	34%	49 686	37%	54 537	38%
Private for-profit share	31 865	30%	40 989	33%	42 616	34%	43 742	32%	46 926	33%
Flemish region	**54 744**		**61 685**		**64 015**		**71 069**		**78 841**	
Public share	22 155	40%	23 697	38%	23 550	37%	24 226	34%	24 666	31%
Private non- profit share	26 217	48%	29 580	48%	31 275	49%	36 259	51%	40 974	52%
Private for-profit share	6 372	12%	8 408	14%	9 190	14%	10 584	15%	13 201	17%
Walloon region	**37 904**		**45 322**		**47 071**		**48 532**		**49 812**	
Public share	11 741	31%	12 715	28%	13 018	28%	13 455	28%	13 897	28%
Private non-profit share	8 721	23%	9 844	22%	10 181	22%	11 378	23%	11 629	23%
Private for-profit share	17 442	46%	22 763	50%	23 872	51%	23 699	49%	24 286	49%
Brussels region	**13 877**		**15 785**		**15 381**		**15 147**		**15 108**	
Public share	3 959	29%	3 912	25%	3 792	25%	3 639	24%	3 735	25%
Private non-profit share	1 867	13%	2 055	13%	2 035	13%	2 049	14%	1 934	13%
Private for-profit share	8 051	58%	9 818	62%	9 554	62%	9 459	62%	9 439	62%

Source: See also Pacolet J. et al. (2018).

References

Agentschap Zorg en Gezondheid, Vlaamse sociale bescherming zal 4 miljard euro omvatten, https://www.zorg-en-gezondheid.be/vlaamse-sociale-bescherming-zal-4-miljard-euro-omvatten.

Agentschap Zorg en Gezondheid (2016), Vlaams indicatorenproject woonzorgcentra: kwaliteitsindicatoren 2016 deel 1.

Agentschap Zorg en Gezondheid, Vlaams indicatorenproject woonzorgcentra: (VIP WZC) https://www.zorg-en-gezondheid.be/vlaams-indicatorenproject-voor-woonzorgcentra-vip-wzc.

Agentschap Zorg en Gezondheid (2015), Kwaliteit van zorg in woonzorgcentra: meten via kwaliteitsindicatoren 2015 deel 2.

Agentschap Zorg en Gezondheid (2017), Resultaten van de bevraging in woonzorgcentra over de kwaliteit van leven, Results for individual instiutions, https://www.zorg-en-gezondheid.be/resultaten-van-de-bevraging-in-woonzorgcentra-over-de-kwaliteit-van-leven.

Agentschap Zorg en Gezondheid (2018), Hoeveel bedraagt de gemiddelde dagprijs in uw woonzorgcentrum? Meting 2017, https://www.zorg-en-gezondheid.be/dagprijzen.

AVIQ, Transfert de compétences, https://www.aviq.be/transfert.html.

AVIQ, Reglementation applicable à l'hébergement et à l'accueil des aînés en Wallonie. Coordination officieuse au 01/01/2016, http://sante.wallonie.be/sites/default/files/aines_reglementation.pdf.

Commission Staff Working Document, Country Report Belgium 2018 Accompanying the document Communication from the Commission to the European Parliament, the Council, the European Central Bank and the Eurogroup 2018 European Semester: Assessment of progress on structural reforms, prevention and correction of macroeconomic imbalances, and results of in-depth reviews under Regulation (EU) No 1176/2011.

De Brouwer, H., Verte, D., Dumont, D., De Blander, R., Mahieu, C., Vandenbroucke, A., Slautsky, E., De Spiegelaere, M. & De Greef, V. (2016), Vers une assurance autonomie bruxelloise, ULB.

De Wispelaere F. & Pacolet J. (2016), ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives – Belgium. Brussels: European Commission – Directorate-General for Employment, Social Affairs and Inclusion.

De Wispelaere F. & Pacolet J. (2017), 'Supporting measures in Belgium for persons with dependent relatives', in Reinschmidt L. & Pieper J. (eds), How do European countries support family carers? A look at work-life balance policies in Germany, Austria and Belgium, Observatory for Sociopolitical Developments in Europe, Newsletter 2017.

De Coninck, A. & Pacolet J. (2017), The role of the private providers in nursing homes and residential care in Belgium, contribution to the Eurofound report Molinuevo D. & Anderson R. (2017), Care homes for older Europeans: Public, for-profit and non-profit providers, Eurofound, HIVA, Leuven.

Dienststelle für Selbstbestimmtes Leben der Deutsprachige Gemeinschaft Belgiens,

http://selbstbestimmt.be/.

Departement Werk en Sociale Economie (2017), Evaluatie van het vlaamse stelsel van de dienstencheques voor buurtdiensten en –banen, Jaarrapport 2016.

Duyck J., Paul J.-M. & Vandresse M. (2018), Perspectives démographiques 2016-2060: analyses de sensibilité, scénarios alternatifs et effets budgétaires et sociaux, Federal Planning Bureau, Working Paper 1-18.

Eurofound (2017), Care homes for older Europeans: Public, for-profit and non-profit providers, Publications Office of the European Union, Luxembourg.

European Commission (2015), The 2015 Ageing Report. Economic and budgetary projections for the 28 EU Member States (2013-2060). European Economy 3|2015. ISSN 1725-3217, 404 p.

European Commission (2014), The 2012 Ageing Report. Underlying Assumptions and Projection Methodologies. European Economy 8|2014. ISSN 1725-3217, 436 p.

European Commission (2017), The 2018 Ageing Report. Underlying Assumptions & Projection Methodologies. European Economy Institutional Paper 065 | November 2017.

Federal Government (2015), *Strategic Social Reporting 2015*, Brussels: Federal Government, 13 p.

Federal Planning Bureau (2014), Economic Policy Committee's Ageing Working Group. Belgium: Country Fiche 2014. Contribution to the EC-EPC 2015 Ageing Report, forthcoming, 53 p., http://www.plan.be/.

Federal Planning Bureau (2015), De budgettaire gevolgen van de vergrijzing voor België tot 2060. Raming van maart 2015 met de hervormingen van de regering Michel, 17 p., http://www.plan.be/.

Federale Overheidsdienst Sociale Zekerheid, Vade Mecum van de cijfergegevens van de sociale bescherming in België – statistisch gedeelte. Periode 2011-2015.

Federale Overheidsdienst Sociale Zekerheid (2017), Tegemoetkoming voor hulp aan bejaarden (THAB), http://handicap.belgium.be/nl/mijn-rechten/tegemoetkoming-hulp-bejaarden.htm

Federale Overheidsdienst Sociale Zekerheid, Directie-Generaal Personen met een handicap, Jaaroverzicht in cijfers 2014, http://handicap.belgium.be/nl/contact/publicaties/jaaroverzicht-cijfers-2014.htm.

Gerard M., Romainville J.-F. & Valsamis D. (2014), Evaluatie van het stelsel van de dienstencheques voor buurtdiensten en –banen 2013, Idea Consult.

Gouvernement Wallon. (2014), Oser, innover, rassembler 2014-2019, Namur: Gouvernement wallon, 121 p.

Greoli A., Ministre de l'Action sociale et de la Santé (2017), L'assurance-autonomie proposera un soutien à tout âge et quel que soit le lieu de résidence.

Group S, Human Resources Management Solutions, 13-01-2017,Werkbaar en wendbaar werk : tijdskrediet, nieuw in 2017 !, https://www.groups.be/1_82021.htm

Janssens A.(2018), Vlaamse aanmoedingspremie voor mantelzorg moet verdubbelen, Visie, p. 12.

Lipszyc B., Sail E. & Xavier A. (2012), 'Long-term care: need, use and expenditure in the EU-27', Economic Papers 469, Directorate-General for Economic and Financial Affairs. See: http://ec.europa.eu/economy_finance/publications/economic_paper/2012/pdf/ecp469_en.pdf.

MISSOC (2015), Comparative tables on social protection, Brussels: MISSOC.

Molinuevo D. & Anderson R., (2017), Care homes for older Europeans: Public, for-profit and non-profit providers, Eurofound, Publications Office of the European Union, Luxembourg.

Pacolet J. (2013), 'Vieillissement, soins de santé et soins aux personnes âgées' in, Integrale, Ethias, P&V, 'Les défis économiques et budgétaires du vieillissement en Belgique': http://www.pv.be/fileadmin/user_upload/NTCdocument/Colloque_Actes_FR_fi1_1421215672.pdf.

Pacolet J. & Bouten R. (1999), National Reports Series of the Social Protection for Dependency in Old Age in the 15 EU Member States and Norway.

Pacolet J., Bouten R., Lanoye H. & Versieck K. (1999), Social protection for dependency in old age in the 15 EU Member states and Norway. Synthesis report, Office for Official Publications of the European Communities, Luxembourg, 159 p.

Pacolet J., Bouten R., Lanoye H. & Versieck K. (2000), Social Protection for Dependency in Old Age in the 15 EU Member states and Norway. Volume 2. Statistical and Institutional Annexes, HIVA, Leuven, 348 p.

Pacolet J., Bouten R., Lanoye H. & Versieck K. (2000), Social Protection for Dependency in Old Age. A Study of the Member States and Norway, Ashgate, Aldershot, xviii + 337 p.

Pacolet J. & De Coninck A. (2015), Financiering van de residentiële ouderenzorg: het perspectief van de voorzieningen. Steunpunt Welzijn, Volksgezondheid en Gezin.

Pacolet J., De Coninck A. & De Wispelaere F. (2013), Financiering van de thuiszorg: het perspectief van de voorzieningen, Steunpunt Welzijn, Volksgezondheid en Gezin, Leuven.

Pacolet J. & De Wispelaere F. (2015), 'De staat van de verzorgingsstaat in België omstreeks 2015', *Belgisch Tijdschrift voor Sociale Zekerheid, 2015/4.*

Pacolet J. & De Wispelaere F. (2015), 'l'Etat de l'état-providence en Belgique aux alentours de l'année 2015', *Revue Belge de Sécurité Sociale, 2015/4*.

Pacolet J. & De Wispelaere F. (2016), ESPN Thematic Report on Supporting measures in Belgium for persons with dependent relatives. ESPN Report.

Pacolet J. & De Wispelaere F. (2018), ESPN Thematic Report on challenges in long-term care – Luxembourg. Brussels: European Commission – Directorate-General for Employment, Social Affairs and Inclusion.

Pacolet J., De Wispelaere F. & Vanormelingen J. (2014), De ontbrekende schakel: een echte meerwaardebelasting voor België. *De Gids op Maatschappelijk Gebied.* VZW Vormingscentrum ter Munk & Garant nr.105, pp. 35-42.

Pacolet J., De Wispelaere F. & De Coninck A. (2011), De dienstencheque in Vlaanderen. Tot uw dienst of ten dienste van de zorg? (Service Coupons in Flanders. At your service, or at the service of care?), Steunpunt Welzijn, Volksgezondheid en Gezin, April 2011.

Pacolet J., Hedebouw G. & Winters S. (eds) in collaboration with Rodriguez Cabrero G., O'Shea E., Varaama M. & Yfantopoulos Y. (2001), Time to care. The cost of formal and informal care for persons with Alzheimer's disease, HIVA- KU Leuven, Leuven.

Pacolet J., Luyten J., Op de Beeck L., De Wispelaere F., De Coninck, A. & Kuppens S. (2018), Onderzoek naar de noodzaak van en de voorwaarden voor de ontwikkeling van een duurzaam systeem van prijzencontrole voor de residentiële ouderenvoorzieningen in Vlaanderen, Leuven, HIVA Onderzoeksinstituut voor Arbeid en Samenleving en LIGB Leuvens Instituut voor Gezondheidszorgbeleid, 176 blz.

Pacolet J., Merckx S., Spruytte N. & Cabus S. (2010), Naar een verbeterde tenlasteneming van de kosten van niet-medische zorg thuis. Leuven: HIVA-K.U.Leuven.

Pacolet J., Vanormelingen J. & De Coninck A. (2014), Tempus Fugit. Een aggiornamento van toekomstverkenningen voor de zorgberoepen in de Vlaamse Gemeenschap. Over.werk. Tijdschrift van het Steunpunt WSE, 24 (4), 98-107.

Pacolet J. & Vanormelingen J. (2014), Working longer after arduous jobs. ESPN Report.

Pacolet J., Vanormelingen J. & De Coninck A. (2016), ESPN Thematic Report on Retirement regimes for workers in arduous and hazardous jobs. ESPN Report.

Prévot, M. (2017), Plan papy boom. Une réforme ambitieuse et inédite du secteur des maisons de repos et maisons de repos et de soins, PowerPoint. Namur, 24-05-2017.

RIZIV, Medisch verbruik vanuit geografisch perspectief - Variaties in de uitgaven van de verzekering voor geneeskundige verzorging in België – Longitudinaal rapport 2009-2013.

RVA (2013), Impact van het dienstenchequesysteem op de uitstroom uit de werkloosheid.

Socialistische Mutualiteiten (2016), Rusthuisbarometer. Analyse bewonersfacturen van de woonzorgcentra.

Studiecommissie Vergrijzing (2017). Jaarverslag 2017.

Studiecommissie Vergrijzing (2015). Jaarverslag 2015.

Vandeurzen, J. (2017), Residentiële ouderenzorg, een échte thuis voor kwetsbare personen. Een stevige uitdaging voor de samenleving én zorgaanbieders. Conceptnota/Ter , Vlaamse Regering, De Vlaamse Minister van Welzijn, Volksgezondheid en Gezin, december 2017.

Van den Bosch K. (2016), Measuring social protection for older people with long-term care needs in Belgium. A report on the completion of an OECD data collection questionnaire, Federaal Planbureau, Brussels.

Van den Bosch K., Geerts J. & Willemé P. (2013), 'Long-term care use and socio-economic status in Belgium: a survival analysis using health care insurance data', *Archives of Public Health*.

Vlaamse Regering (2014), Regeerakkoord Vlaamse Regering 2014-2019, Brussels: Vlaamse Overheid, 197p.