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REPORT

Measuring social protection for older people with long-term care needs in Belgium. A report on the completion of an OECD data collection questionnaire

June 2016

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Abstract - Social protection for the costs of long-term care (LTC) varies widely between countries, and to date there has been no systematic comparison of this issue. In response to this information gap, the OECD and the European Commission (EC) have established a project to make quantitative comparisons of social protection for long-term care in OECD and EU countries, using the typical cases approach. Social protection encompasses both cash benefits, conditional on long-term care needs, and long-term care services offered at no or subsidized cost to the user. A data collection questionnaire has been distributed. This report describes how the data for Belgium have been collected. The following schemes are taken into account: the allowance for the assistance of the elderly; the allowances for incontinence and for the chronically ill; the Flemish care insurance; the sickness and invalidity insurance for home nursing care and care in institutions; home care (not nursing care), regulated and subsidized by regional governments; and service vouchers. The data refer to the year 2015.

The results indicate that most of the total costs of long-term care are borne by the various public systems. For older people with severe needs the personal costs of residential care are mostly affordable, but this is not necessarily the case for those with moderate or low needs for long-term care.

Jel Classification - H24, H42, H51, H55, I13, I18
Keywords - Long-term care, Social protection, Ageing

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Executive summary

Social protection for the costs of long-term care (LTC) varies widely between countries, and to date there has been no systematic comparison of the experiences of people with LTC needs in different countries. In response to this information gap, the OECD and the European Commission (EC) have established a project to make quantitative comparisons of social protection for LTC in OECD and EU countries, using the typical cases approach. Social protection encompasses both cash benefits, conditional on long-term care needs, and long-term care services offered at no or subsidized cost to the user. A data collection questionnaire has been distributed. This report describes how the data for Belgium have been collected. The following schemes are taken into account: the allowance for the assistance of the elderly; the allowances for incontinence and for the chronically ill; the Flemish care insurance; the sickness and invalidity insurance for home nursing care and care in institutions; home care (not nursing care), regulated and subsidized by regional governments; and service vouchers. The data refer to the year 2015.

The results show that, firstly, the costs of care met directly by the government (through the social health insurance system, subsidies to home care providers and subsidies and tax allowances for service vouchers) far outweigh the cash benefits that are conditional on dependency paid by the federal and regional governments. Secondly, in all cases of home care most of the total costs are borne by the various public systems, from 72% for the "low need - high income" case to 100% for the "high need - low income" case. Generally, the coverage rate increases with severity of need and decreases with income. Thirdly, for older people with severe needs the costs of residential care are mostly affordable, thanks to the allowance for the assistance of the elderly, and (if eligible) the Flemish care insurance. Older persons with moderate or low needs for long-term care and a low pension could experience problems to pay for residential care.

Synthèse

La protection sociale des soins de longue durée varie amplement selon les pays et, à ce jour, aucune comparaison systématique des expériences de patients recourant à ces soins dans différents pays n'a été réalisée. Face à ce déficit d'informations, l'OCDE et la Commission européenne (CE) ont lancé un projet visant à comparer quantitativement, par la méthode des cas types, la couverture sociale des soins de longue durée dans les pays de l'OCDE et de l'UE. La protection sociale englobe à la fois les prestations en espèces conditionnées par les besoins en soins de longue durée et les services de soins de longue durée gratuits ou subventionnés. Un questionnaire a été distribué en vue de la collecte de données. Ce rapport précise comment les données pour la Belgique ont été obtenues. Les prestations suivantes ont été prises en considération : l'allocation pour l'aide aux personnes âgées, les interventions forfaitaires pour incontinence et pour malades chroniques, les prestations de l'assurance soins flamande, la couverture par l'assurance maladie et invalidité des soins infirmiers à domicile et des soins en institution, les soins à domicile (en dehors des soins infirmiers) encadrés et subventionnés par les gouvernements régionaux et les titres-services. Les données se réfèrent à 2015.

Les résultats montrent que, premièrement, les coûts des soins qui sont payés directement par le gouvernement (à travers le système d'assurance-maladie sociale, les subventions aux prestataires de soins à domicile et subventions et abattements fiscaux pour les titres-services) dépassent de loin les prestations en espèces conditionnelles à la dépendance des gouvernements fédéral et régional. Deuxièmement, dans tous les cas types de soins à domicile la plupart des coûts totaux sont pris en charge par les différents systèmes publics, de 72 % pour le cas « faible besoin - haute revenu » à 100 % pour le cas « besoin élevé - bas revenu ». En général, le taux de couverture augmente avec la gravité du besoin et diminue avec le revenu. Troisièmement, les personnes âgées les plus dépendantes généralement pourront se permettre des soins résidentiels, grâce à l'allocation d'aide aux personnes âgées et l'assurance soins flamande. Pour les personnes âgées ayant des besoins de soins faibles à moyens et touchant une pension plutôt basse, des problèmes d'accessibilité financière peuvent se poser.

Synthese

De sociale bescherming voor de kosten van langdurige zorg verschilt aanzienlijk tussen landen onderling en tot op heden ontbreekt een systematische vergelijking van de ervaringen van mensen met behoefte aan langdurige zorg in verschillende landen. Als antwoord op deze informatiekloof hebben de OESO en de Europese Commissie (EC) een project opgezet om kwantitatieve vergelijkingen te maken van de sociale bescherming voor langdurige zorg in OESO- en EU-landen, waarbij ze gebruikmaken van de methode van type-gevallen. Sociale bescherming omvat zowel uitkeringen – voorzover deze afhankelijk zijn van de behoefte aan langdurige zorg – als diensten voor langdurige zorg die kostenloos of tegen gesubsidieerde prijs aan de gebruiker worden aangeboden. Een vragenlijst werd verspreid. Dit rapport beschrijft op welke manier de gegevens voor België werden verzameld en verwerkt. De volgende regelingen worden in aanmerking genomen: de tegemoetkoming voor hulp aan bejaarden; de forfaitaire uitkeringen voor incontinentie en chronisch zieke patiënten; de Vlaamse zorgverzekering; de ziekte- en invaliditeitsverzekering voor thuisverpleging en zorg in instellingen; de door de regionale overheden gereguleerde en gesubsidieerde thuiszorg (geen verpleegzorg); en dienstencheques. De gegevens hebben betrekking op 2015.

De resultaten tonen, ten eerste, dat de kosten van langdurige zorg die direct gedragen worden door de overheid (via de sociale ziekteverzekering, de subsidies aan de verleners van thuiszorg en de subsidies en belastingvoordelen ten gunste van dienstencheques) veel omvangrijker zijn dan de toelages in geld voor personen in afhankelijkheid die uitgekeerd worden door de federale en regionale overheden. Ten tweede wordt voor alle type-gevallen met thuiszorg het grootste deel van de kosten gedragen door de diverse sociale systemen, van 72 % voor het type-geval “lage behoefte - hoog inkomen” tot 100 % voor het type-geval “hoge behoefte - laag inkomen”. In het algemeen neemt de beschermingsgraad toe met stijgende behoefte en daalt ze naargelang het inkomen hoger is. Ten derde blijkt dat de kosten van residentiële zorg voor de meest zorgbehoevende ouderen meestal haalbaar zijn, dankzij de tegemoetkoming voor hulp aan bejaarden en eventueel de Vlaamse zorgverzekering; voor ouderen lage of middelmatige zorgbehoeften en een beperkt pensioen kunnen er wel betaalbaarheidsproblemen zijn.

Introduction

At present, fairly little is known about the extent and adequacy of social protection for older people with long-term care needs. Given the large differences in public expenditure on long-term care across countries of the European Union (Council of the European Union, 2014), it is likely that there is much variation in the degree to which social protection meets the costs of long-term care. For this reason the OECD (Directorate for Employment, Labout and Social Affairs) has started together with the European Commission (DG Employment, Social Affairs and Inclusion) a project to map the extent of social protection, using the 'typical cases' approach. A questionnaire has been distributed to all EU and OECD Member states, presenting five cases of older persons in different situations, and asking which public cash benefits or benefits in kind these people would be entitled to, or could reasonably expect to receive. The cases are defined in terms of ADL (Activities of Daily Living) needs, IADL (Instrumental Activities of Daily Living) needs and social needs, the kind and number of hours of care they receive, their income and living situation. The cases are:

1. "Home care for low needs", no informal care
2. "Home care for moderate needs", no informal care
3. "Home care for high needs", no informal care
4. "Informal care for moderate needs", no formal care
5. "Institutional care for high needs".

For each case, three levels of income are specified ('Low': € 256.25; 'Median': € 342.29; 'High': € 496.32; all per week), and two levels of assets (zero assets, and very high assets above any relevant threshold). In the simulations below, these incomes are assumed to consist of pensions (retirement, widows or IGO) only, and specifically do not include earnings, nor any of the benefits directed to persons with LTC needs, as otherwise the calculations become unmanageable. For further details I refer to the questionnaire in Appendix.

This report presents and records the details about how the questionnaire has been completed for Belgium. In addition to the description of the cases, it has been assumed that the persons concerned live in Flanders. Both cash benefits and benefits in kind vary across regions in Belgium. Flanders is the most populous region of Belgium, and its regulations are generally well documented and available on the internet. Given the information collected, it was a fairly small step to extend the calculations to all levels of pension widen.

The following schemes were taken into account when completing the questionnaire:

1. **Allowance for the assistance of the elderly.** A cash allowance with five levels of payment, income and assets – dependent.
2. **Incontinence allowance**. Federal Allowance for the costs of incontinence for severely incontinent persons not in residential care.
3. **The allowance for the chronically ill.** Federal allowance for chronically ill persons who are strongly dependent on others.
4. **Care insurance benefit (Flanders only).** A flat rate cash benefit paid to people with care needs

5. **Sickness and invalidity insurance.** This pays the cost of care services for dependent people, both at home (partly) and in institutions (completely).
6. **Home care (not nursing care)** Subsidized home care (except nursing care), provided by private (generally not-for-profit) or public organizations. Prices for users are regulated by Regional governments; in Flanders these are income-dependent.
7. **Service vouchers.** Tax-subsidized vouchers for household tasks

Mapping the cases on the Belgian LTC system

In order to determine the level of cash benefits, as well as the kind of nursing care to which the persons described in the cases would be entitled in Belgium (Flanders), we had to map the characteristics of the cases, as described in the OECD questionnaire onto the categories and scales used in the various schemes described above. In particular, it is necessary to assign a score on the various dependency scales used in Belgium, to determine whether they were entitled to the increased reimbursement within the sickness and invalidity insurance, and which was the relevant threshold for the application of the maximum billing system within the same scheme.

Degree of dependency

First, it was necessary to assign a score on the dependency scales used in Belgium to each of the cases. Unfortunately, different schemes use different dependency scales. Moreover, assigning a score is a matter of judgment. In Table 1 we provide relevant details on these scales, as well as the assigned to each of the cases.

Table 1 Dependency scales used in determining entitlement to LTC cash benefits and benefits in kind

	'Autonomy scale'	'Katz'-scale	'BEL'-scale (Flanders)
Scheme used for:	Allowance for the assistance of the elderly	Sickness and invalidity insurance, Incontinence Allowance	Care insurance benefit, Home care
Measures mainly:	ADL & IADL needs	ADL needs	ADL, IADL and social needs
Normally assessed by:	Medical doctor	Nurse, doctor	Practitioner
Possible values	0-18 points	A, B, C	0-75 points
Score case 1:	6	-	13
Score case 2:	12	A	25
Score case 3:	17	C	52
Score case 4:	12	A	27
Score case 5:	17	C	52

Income-dependent categories in the sickness and invalidity insurance

Pensioners (and others) with a low household income (for singles less than € 16,965.47 per year in 2015), as well as all persons who receive certain allowances, including the allowance for the assistance of the elderly, are entitled to increased reimbursement within the federal sickness and invalidity insurance.

This means that they receive higher reimbursements for many health care treatments, and therefore have smaller out-of-pocket costs.

Furthermore, the federal sickness and invalidity insurance applies a maximum billing system to co-payments. If the total co-payments of a household during a calendar year exceeds a threshold, no more co-payments are imposed during the rest of the year, and reimbursement is complete. The threshold is income-dependent. For those enjoying the increased reimbursement it is € 450 per year.

Table 2 Increased reimbursement and maximum-billing thresholds

	Low assets Low income	Low assets Median income	Low assets High income	High assets Low income	High assets Median income	High assets High income
Income per month	1110	1483	2151	1110	1483	2151
Income per year	13325	17799	25809	13325	17799	25809
Increased reimbursement?						
- Case 1	Yes	No	No	Yes	No	No
- Cases 2-5:	Yes	Yes (1)	No	Yes	No	No
Maximum billing threshold:						
- Case 1	450	650	650	450	650	650
- Cases 2-5:	450	450	650	450	450	650

(1) Increased reimbursement because case is entitled to Allowance for the assistance of the elderly. This is not so, if case has high assets. The maximum billing threshold depends on being entitled to increased reimbursement.

Cash benefits

Given the characteristics of the cases mapped onto the Belgian schemes as described above, it is possible to determine the cash benefits to which these persons would be entitled. Below I describe how this was done in detail.

Allowance for the assistance of the elderly

This cash allowance, paid by the federal government, has five levels of payment, corresponding to five levels of dependency, assessed using the autonomy scale discussed above. It is means-tested against the income of the applicant and his/her partner, and also to a certain extent against their assets, though in a quite complicated way.[1] Pensions are only taken into account for 90%, but earnings, as well as the means-tested Income Guarantee for Older people (IGO/GRAPA) for 100%, while a number of other income components (e.g. maintenance allowances) are totally disregarded. For financial assets 6% of the total value is taken into account; it is not entirely clear whether the actual income from these assets is included in this percentage and does or does not have to be declared separately. The 6% rule is also applied to the net proceedings of recent sales of any assets, as well as the real value of recent gifts. The rent imputed to real estate for fiscal purposes ("revenue cadastral") is added to income, but only after a deduction of € 1,500. Since the third quartile of this income component is only € 1,200[2], this deduction

1 FOD Sociale Zekerheid, Directie Generaal Personen met een Handicap: "De tegemoetkoming voor hulp aan bejaarden", versie 2-6-2015, http://handicap.fgov.be/sites/5030.fedimbo.belgium.be/files/explorer/nl/brochure-thab.pdf downloaded 30/9/2015

2 Source: BE-SILC 2013, own computations. The amount refers to the distribution of imputed rent for the owner-occupied home only.

means that for the large majority of beneficiaries, imputed rent for their own homes is not taken into account. From the total income as calculated following the rules sketched a threshold is exempted. In 2015 these thresholds were € 16,100 for beneficiaries who had dependents (e.g. children with no income), and € 12,900 for all others. Income above these thresholds is deducted from the maximum benefit.

The degree of autonomy is assessed on six dimensions: mobility, preparing meals and eating, personal care and dressing, maintenance of the home and household work, evaluating and avoiding dangerous situations, maintaining social relations. Difficulties on each dimension are given a score from 0 to 3; the sum of these scores – the maximum score is 18 – determines the dependency category. 0-6 points: no benefit; 7-8 points: category 1; 9-11 points: category 2; 12-14 points: category 3; 15-16 points: category 4; 17-18 points: category 5. Given the scores assigned to the cases (Table 1), the maximum benefits for cases 2 and 4 was € 4,556 (category 3) and for cases 3 and 5 was € 65,890 (category 5).

The OECD questionnaire states that the assets of the high-asset cases are above any relevant threshold, so a financial capital of 1 billion Euros is assumed, which implies that these cases receive no benefit. Furthermore, the assumption is made that the whole (non-asset) income consists of pensions (of which 90% is taken into account). These assumptions lead to the amounts presented in Table 3.

Incontinence allowance

The incontinence allowance is a fixed compensation for the costs of incontinence material paid by the federal public health insurance.[3] There are in fact two kinds of incontinence allowance: one for persons suffering from incontinence but not dependent, and the other one for people who are incontinent and heavily dependent (score B or C on the Katz scale of home nursing care). Neither are means-tested. In both cases, persons in residential care are excluded from this benefit (because the costs of any incontinence material needed is included in the price paid by residents). For non-dependent persons, the yearly amount is € 161; for dependent persons it is € 493. The latter is used here for cases 3 and 5.

Allowance for the chronically ill

The allowance for the chronically ill is a yearly non-means-tested fixed compensation for the costs of care paid by the federal public health insurance.[4] It is intended for chronically ill persons who are strongly dependent on others. It is conditional both on having high out-of-pocket care costs, and on being dependent on others.[5] Only persons who in the reference year and the year before paid at least 450 Euros in personal contributions for health care are eligible; this threshold is reduced to 360 Euros for persons with increased reimbursement. Dependency is measured in three categories. Several situations can qualify a person for the first category, including being prescribed physiotherapy for at least six months for a serious illness, and having been in hospital for at least 120 days. A score of at least 12 on the 'Autonomy scale' is sufficient to qualify for the second category, while a score of B or C on the

3 Website Christelijke Mutualiteiten http://www.cm.be/diensten-en-voordelen/thuiszorg/forfaits/incontinentieforfait/index.jsp
4 Website Christelijke Mutualiteiten http://www.cm.be/diensten-en-voordelen/thuiszorg/forfaits/incontinentieforfait/index.jsp
5 Website NIHDI http://www.inami.fgov.be/nl/themas/kost-terugbetaling/ziekten/chronische-ziekten/Paginas/forfait-chronisch-zieken.aspx#.V1O7pY9OI2w

Katz scale is necessary to qualify for the third category. The yearly amounts in 2015 corresponding to the three categories were € 300.11, € 450.18 € and € 600.23, respectively.

Care insurance benefit

The Flemish care insurance benefit[6] is a flat-rate allowance to cover the non-medical costs of informal care and formal home care, as well as the costs of residential care, for inhabitants of Flanders and Brussels. It is granted to very dependent persons, as indicated by a score of at least 35 on the BEL scale, or 15 on the Autonomy scale used for the Allowance for the assistance of the elderly, or a score of B or C on the Katz scale used by the NIHDI for home nursing care. For persons in residential care, dependency is automatically assumed. Currently, the benefit is a fixed amount of € 130 per month, which is not means tested.

Table 3 Cash benefits for long-term care needs, by dependency, level of income and of assets *

	Low assets Low income	Low assets Median income	Low assets High income	High assets Low income	High assets Median income	High assets High income
CASE 1:						
Federal allowance	0	0	0	0	0	0
Flemish care insurance	0	0	0	0	0	0
Total	0	0	0	0	0	0
CASES 2, 4:						
Federal allowance	4556,11	1437,70	0	0	0	0
Flemish care insurance	0,00	0,00	0	0	0	0
Total	4556,11	1437,7	0	0	0	0
CASE 3:						
Federal allowance	6589,77	3489,13	0	0	0	0
Allowance for incontinence (federal)	493,15	493,15	493,15	493,15	493,15	493,15
Flemish care insurance	1560,00	1560,00	1560,00	1560,00	1560,00	1560,00
Total	8642,92	5542,28	2053,15	2053,15	2053,15	2053,15
CASE 5:						
Federal allowance	6589,77	3489,13	0	0	0	0
Allowance for incontinence (federal)	0	0	0	0	0	0
Flemish care insurance	1560,00	1560,00	1560,00	1560,00	1560,00	1560,00
Total	8149,77	5049,13	1560,00	1560,00	1560,00	1560,00

* The allowance for the chronically ill is not included in this table, as it is dependent on out-of-pocket care expenses for health care being higher than a threshold. So, given the specifications of the cases (in particular the condition that they no health care problem apart from the handicaps specified), this depends on the care packages chosen (see below). It turns out only the high-income case qualifies.

6 Website Vlaams Agentschap Zorg en Gezondheid http://www.zorg-en-gezondheid.be/Vlaamse-zorgverzekering/Recht-op-tegemoetkoming/

Benefits in kind

Introduction

Older persons in need of care can enter residential care, where care (as distinguished from accomodation) is completely paid for by public funds (see below). If they choose to continue to live in their own homes[7], they can use care services which are subsidized or partially or wholly reimbursed from public funds. In fact there are three systems, which provide services that are overlapping but are not identical. These are:

1. **Nursing care, reimbursed by the Federal Public Health Insurance (NIHDI) ("verpleegzorg").** This is in principle limited to medical interventions, but can also include some personal care such as washing and dressing.
2. **Personal home care (not nursing care) and additional home care ("gezinszorg" and "aanvullende thuiszorg")** Personal home care includes personal care, household help and cleaning, as well as psychosocial support. Additional home care offers cleaning, accompaniment ("oppashulp") and home repair and maintenance ("karweihulp"). (Pacolet et al., 2013:29-30)
3. **Service vouchers.** The purposes for which tax-subsidized vouchers can be used have been clearly circumscribed, and are limited to cleaning (including the windows), laundry and ironing, mending of cloths, and preparing meals. Also allowed are doing the daily shopping and transporting persons with limited mobility.

This system implies that persons needing care can compose several packages of care services. While there are data on the overall use of the care services mentioned, it is not clear which packages are chosen in particular care situations. For this reason, for each of the cases 1-3 in the OECD questionnaire, several options have been specified and costed. These are presented briefly below, after a discussion of each of the home care services. At the end, one option is chosen as the most plausible.

Nursing care

Nursing care can be provided by self-employed nurses, or by nurses employed by (generally not-for-profit) private organizations. As is true for the public health insurance in general, payment is not per hour, but per specific service. As the cases are assumed to have no health problems apart from their dependency, we assume that only the fixed fees per day of care for heavily dependent patients ("forfaitaire honoraria per verzorgingsdag voor zwaar zorgafhankelijke patiënten") are charged. These are graded by degree of dependency according to the Katz scale (see Table 1), and also depend on whether care is given during weekdays or on Saturday or Sunday, as shown in Table 4. Reimbursement is higher (and therefore user contributions are lower) when the patient has the status of increased reimbursement (see Table 2). (It is assumed the nurse has agreed to the convention ("conventionné") between nurses and mutualities about fees and conditions)

[7] In the literature this is often referred to as "living in the community", which seems to have the unfortunate and often factually incorrect implication that users of residential care are necessarily outside the community.

Table 4 Fees, reimbursements and user contributions for nursing care (2014-2015)

	Fee	Reimbursement normal	User contribution normal	Increased reimbursement	User contribution if increased reimbursement
WEEKDAYS:					
Katz scale A	17,11	12.84	4.27	16.86	0.25
Katz scale B	32.98	29.69	3.29	32.73	0.25
Katz scale C	45.12	40.61	4.51	44.87	0.25
WEEKENDS:					
Katz scale A	25.55	19.17	6.38	25.30	0.25
Katz scale B	48.97	44.08	4.89	48.72	0.25
Katz scale C	67.19	60.48	6.71	66.94	0.25

Source: RIZIV (NIHDI), http://www.inami.fgov.be/SiteCollectionDocuments/tarief_verpleegkundigen_20150101.pdf

In addition to these amounts, we have to take account of the maximum billing system. The maximum billing system means that health care users are fully reimbursed from the moment their users's contribution during a calendar year exceeds the relevant threshold, which are income dependent (see Table 2). Assuming that the cases use the same amount of care during all weeks of the year, some of the cases without increased reimbursement will reach the maximum billing threshold, even in the (very unlikely) situation that the care receiving person has no other medical costs. The resulting implicit reduction in user's contribution is distributed across all weeks. The total costs for nursing care for cases 2 and 3 (case 1 is not eligible) are shown in Table 5. Note that for case 3, nursing care is assumed to cover only washing and dressing, not eating (see below). Only the high-income cases reach the maximum billing thresholds, as user's contributions for persons with increased reimbursement status are very low. However, if the latter would have other out-of-pocket medical costs (as would be most likely in reality) sufficient to reach the maximum billing threshold, their contribution would in fact be even lower still.

Thirdly, we have to take account of allowance for the chronically ill. As this depends on the out-of-pocket contributions to health care exceed a certain threshold, it is easier to treat it in the calculations as a reduction of costs, rather than as an allowance. As is true for the maximum billing system (and again assuming no other health care costs), only the high income case, which does not qualify for increased reimbursement, becomes eligible. The yearly amount is divided by 52, and included as a reduction.

Table 5 Costs of home nursing care per week for cases with moderate or high needs, by income level

	Days	Total cost	Cost to user, median and low income	Collective support, median and low income	Cost to user high income	Collective support, high income
CASE 2 (Moderate needs, Katz A):						
Weekdays	5	85.55	1.25	84.30	21.35	64.20
Weekends	2	51.10	0.50	50.60	12.76	38.34
Reduction due to maximum billing				-21.61		
Allowance for the chronically ill				-8.66		
Total		136.65	1.75	134.90	3.84	131.06
CASE 3 (High needs, Katz C):						
Weekdays	5	225.60	1.25	224.35	22.55	203.05
Weekends	2	134.38	0.50	133.88	13.42	120.96
Reduction due to maximum billing				-23.47		
Allowance for the chronically ill				-11.54		
Total		359.98	1.75	358.23	0.96	357.27

Source: Own calculations using assumptions in OECD questionnaire and official tariffs and regulations (see Tables 2 and 4)

Personal home care and additional home care

Personal home care is generally provided by private not-for-profit organizations, although public providers and commercial firms are also active in this market. Personal home care is regulated and subsidized by the regional governments, who each year determine the total number of subsidizable number of hours and assign quota to the accredited organizations who are active in this market. They also set the level and structure of subsidies and the user's contribution that the providers can ask. The subsidies consist of a basic amount per hour of care or training (€ 25.79 in 2015), and a host of specific allowance and subsidies for coordination, management and other purposes. [8]

For an estimate of the total costs per hour of home personal care we refer to a study by Pacolet et al. (2013) using the financial accounts of the home care organizations. For the private not-for-profit organizations, who provide the bulk of home care, the average cost of an hour of care given was € 33.88 in 2011; it is slightly higher for public providers. Using the index of average wage costs in the public sector, this amount is updated to € 36.84 in 2014.

The contribution by the user per hour of long-term care[9] depends on income, as well as their household situation, their degree of dependency, the timing of care and the amount of care used. The income of the user, and of other persons of the same generation[10] living within the same household, are taken into account. For single persons the contribution per hour varies from € 3.74 when the income is at the level of the Income Guarantee for Older persons (IGO) to € 10.50 at the "high income" level of € 2,151 per month. The contributions are given in a large table, which shows that the contribution increases with

8 Vlaamse Regering, Agentschap Zorg en Gezondheid, https://www.zorg-en-gezondheid.be/subsidiering_gezinszorg/

9 There are other rules for acute temporary home care.

10 This concept "personen van dezelfde generatie" is not further defined.

income in a seemingly somewhat haphazard way[11]; however, a linear function of income produces a very close approximation which is never more than € 0.10 from the actual value. However, this basic contribution is subject to the following rebates and surcharges:

- a surcharge of 30% is allowed for care given on weekdays during the evenings and nights (after 20h and before 7h) and on Saturdays
- a surcharge of 67% is allowed for care given on Sundays and holidays
- a rebate of 0.65 per hour if the user has a BEL score of at least 35
- an additional rebate of 0.25 per hour if care is received during an uninterrupted period of at least one year, provided the user has a BEL score of at least 35
- an additional rebate of 0.35 per hour if more than 60 hours of care are received per month, provided the user has a BEL score of at least 35
- motivated deviations (upward and downward) from this scheme are possible.

The rebates can be cumulated; however the contribution can never be less than € 0.51 per hour. As home care is not reimbursed by the national (federal) health care insurance, these user's contributions are not included in the maximum billing accounts.

The difference between the hourly cost of care as discussed above, and the user's contribution is regarded as the amount of collective support for long-term care. An administrative, yet important difference between nursing care and personal home care is that patients first pay the full price of nursing care, and afterwards get reimbursed by their mutuality (which in turn is refunded by the NIHDI), receivers of personal home care only have to pay the user's contribution, while home care organizations receive their subsidies directly from the Flemish government.

The user's contribution for *additional* home care is not regulated; home care organizations are free to set their own guidelines. Given lack of information, we assume that they use the same tariffs etc. for additional home care as for personal home care.

Service vouchers

Service vouchers have been introduced to make household work cheaper for consumers, in order to increase employment in this sector, and also to reduce the incentives for undeclared work. The purposes for which tax-subsidized vouchers can be used have been clearly circumscribed, and are limited to cleaning (including the windows), laundry and ironing, mending of cloths, and preparing meals. Also allowed are doing the daily shopping and transporting persons with limited mobility. It is administered by the private firm Sodexo, in collaboration with the National Office for Employment (ONEM/RVA). Users order service vouchers from Sodexo at a fixed price, which they can use to pay accredited providers of the services mentioned. The providers send the (duly completed) vouchers back to Sodexo,

[11] Ministerieel besluit tot vaststelling van het bijdragesysteem voor de gebruikers van gezinszorg, Belgisch Staatsblad 26/07/2001.
Bijlage bij het besluit van de Vlaamse Regering van 25 april 2014 tot wijzing (*sic*) van diverse bepalingen uit de regelgeving betreffende de woonzorgvoorzieningen, Belgisch Staatsblad 61098 20/08/2014 Ed. 2. http://codex.vlaanderen.be/Portals/Codex/documenten/1010255.html

and are reimbursed by that firm at a considerable higher rate than wat the user had originally paid for the vouchers. For this reason, Sodexo receives a fixed subsidy per voucher from the federal government. Morever, users enjoy a tax rebate per voucher ordered. Both the number of vouchers that can be ordered per calendar year, and the maximum total tax rebate are limited, though the thresholds are considerably higher for persons in administratively recognized need of care.

In 2015 the parameters were as follows[12]:

- gross price per voucher for the user: € 9.00 up to 400 vouchers. In addition 100 vouchers can be bought at the price of € 10.00.
- for persons who are officially recognized as handicapped (by regional government offices, *or* who receive the Allowance for assistance of the elderly, *or* who have a score of 7 or higher on the Autonomy scale) the maximum number of vouchers is increased to 1600 per year (at € 9) and 400 per year (at € 10).
- the tax rebate is € 2.70 (for vouchers of € 9) or € 3.00 (for vouchers of € 10), resulting in net prices of € 6.30 and € 7.00. The rebate is refundable, so even those with low incomes who do not pay income taxes profit from it. It is limited to € 1400 at maximum per year (apparently also for persons in need of care).
- Sodexo receives a subsidy of € 13.04 for vouchers of € 9 and of € 12.04 for vouchers of € 10. [13]

We assume that the total cost of one hour of care provided through this scheme costs € 22.04 (9 + 13.04), of which € 15.74 (first 400 vouchers) or € 15.04 (next 100 vouchers), or € 13.04 (next 1200 vouchers), or € 12.04 (next 300 vouchers) represents collective support.

Residential care

For residential care we have to distinguish between accommodation costs and the costs of care proper. We assume that this distinction corresponds exactly to the one between the 'dagprijs' (daily price), paid by the residents, and the expenditure of residential care institutions which is paid for by the government.

Daily price paid by residents

The daily accommodation costs are set independently by each residential care institution. A recent study[14] shows that costs differ by region (Flanders being more expensive than Brussels and especially Wallonia) and type of room (single rooms being about 19 % more expensive than double rooms); see Table 6. However, there is a lot of price variation between institutions that is not explained by these or

[12] http://www.dienstencheques-rva.be/gebruikers/

[13] Federale Overheidsdienst Werkgelegenheid, arbeid en sociaal overleg, Koninklijk besluit tot wijziging van het koninklijk besluit van 12 december 2001 betreffende de dienstencheques, Staatsblad, 17 augustus 2013, Numac 2013204472. http://www.ejustice.just.fgov.be/doc/rech_n.htm

[14] Laasman, J.-M., Maron, L., Van den Heede, A., Van Duynslaeger, M., Vervoort, K. and Vrancken, J. (2016), Maison de repos: à quel prix? Solidaris, Direction Études, Mars 2016. http://www.solidaris.be/Charleroi-Centre-Soignies/Pages/maison-de-repos-a-quel-prix.aspx

other observable factors; prices at the 10th percentile are about 15 percent (Flanders) to 20 percent (Wallonia) lower than at the median. In addition to the daily price, residential institutions can charge supplements for various services that the patient is free to choose or not, such as laundry, pedicure and television. In terms of expenditure, the most important item among these are pharmaceuticals. As can be seen in Table 6, at the median, the difference between the daily price excluding and including supplements is about € 4. An older study by the Federal Public Service for Economic Affairs for 2009, when updated to 2015, quotes slightly lower figures, see Table 6. A study by the Belfius bank[15], based on an analysis of the financial accounts of a large sample of residential institutions in Flanders, shows that in 2013 the total revenue from this source for the population of Flemish residential institutions for older people ('woonzorgcentra') amounted to € 1.22 billion for a total of 25,890,000 person-days. This is equivalent to an average daily price of € 47.12, or € 50.91 when updated to 2015[16].

Table 6 User payments per day by regio, from various sources (updated to 2015)

	Brussels	Flanders	Wallonia
Average daily price (1)	42.83	49.81	39.28
Low price without supplements (2)	35.13	43.81	34.15
Low price including supplements (2)	39.45	46.84	36.42
Median price without supplements (2)	44.16	51.40	41.75
Median price including supplements (2)	49.24	55.27	45.24
Average daily price (3)		50.89	
Price per day for one-person room specific for persons with dementia (4)		52.20	

Notes: Low price refers to 10th percentile of distribution of prices

Sources:

(1) Federale Overheidsdienst Economie, K.M.O., Middenstand en Energie (z.j.), Sectorstudie rusthuizen

(2) Laasman, J.-M., Maron, L., Van den Heede, A., Van Duynslaeger, M., Vervoort, K. and Vrancken, J. (2016), Maison de repos: à quel prix? Solidaris, Direction Etudes, Mars 2016. http://www.solidaris.be/Charleroi-Centre-Soignies/Pages/maison-de-repos-a-quel-prix.aspx

(3) Belfius, De rusthuissector als macro-gegeven in Vlaanderen, mei 2015, https://www.belfius.be/publicsocial/NL/Media/studie%20woonzorgcentra_tcm_31-102568.pdf, downloaded 25-09-2015

(4) VZW Kempenerf, http://www.wzckempenerf.be/2013-09-16-13-35-29/prijzen-kem, read on 25-09-2015

While in principle accomodation costs do not depend on the care intensity, in practice there may be differences, e.g. because one-person rooms are more expensive than two-person rooms. In the residential home "Kempenerf" in Dessel (a small municipality in Flanders) the daily price in a two-person room (the cheapest option) is set at € 44.30, while a one-person room of 20m² in the special ward for demented persons costs € 52.20.[17] Since description of case 5 indicates that the person has advanced dementia and displays agitated or aggressive behaviours, the latter option seemed the appropriate kind of accommodation. A comparison of this price with the other sources quoted in Table 6, as well as the consultation of a number of websites of residential institutions, suggests that within Flanders "Kempenerf" is a relatively cheap home, though certainly not at the bottom of the distribution.[18]

15 Belfius, De rusthuissector als macro-gegeven in Vlaanderen, mei 2015, https://www.belfius.be/publicsocial/NL/Media/studie%20woonzorgcentra_tcm_31-102568.pdf, downloaded 25-09-2015

16 Using the price index for "Rusthuizen en instellingen voor andersvaliden" (12.4.0.2), StatBel.

17 http://www.wzckempenerf.be/2013-09-16-13-35-29/prijzen-kem. Current prices on 19 october 2015.

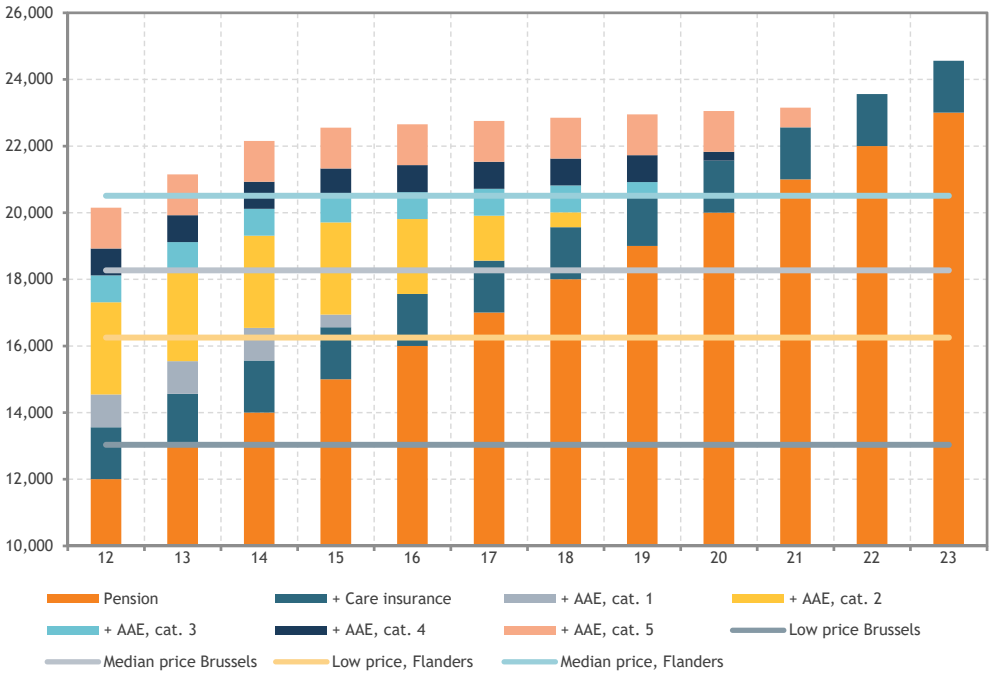
18 Actually, this home is located in the village where I live (we are neighbours), and it seems to have a good reputation.

Affordability of residential care

The data collected on the user cost of care homes, as well as the information on cash benefits to which dependent persons are entitled, makes it possible to compare the total incomes of single persons with various levels of pensions and various degrees of dependency to the costs of residential care. This provides an assessment of the affordability of residential care, which is necessarily imprecise, given the variation in the daily prices charged by residential institutions. In Figure 1, the columns indicate the total incomes of single persons with a certain level of pension, on top of which they receive a care insurance benefit, and depending on the degree of dependence, an allowance for the assistance of the elderly. (Each part of the column indicates the additional income when a person rises on the dependency scale.) The horizontal lines indicate the users' cost, for Brussels and Flanders separately, and at low and median prices on a yearly basis. The low price represents the 10th percentile of the distribution of costs, without supplements. The median price includes supplements.

Figure 1 **Comparison between total incomes of single older persons with various levels of pensions and various degrees of dependency**

Amounts per year in 2015. Vertical scale starts at € 10.000. Horizontale axis indicates pension in '000's €. AAE: Allowance for the Assistance of the Elderly.



Sources: See Table 6 and own calculations

Clearly, from a low to moderate pension plus the care insurance benefit, a room in a residential institute at the median price is not affordable. In Flanders, even the cheapest places are too expensive. However, such persons with no or few care needs are expected to stay in their homes, with the help of home care. On the other hand, for the most dependent persons receiving the maximum allowance for the assistance for the elderly, total income generally exceeds the median daily price. The problem of affordability seems to be most acute for persons with low or moderate pensions, and a moderate degree of dependency.

Public expenditure on residential care

The main source of public revenue for residential institutions are the reimbursements from the National Health Care Insurance (NIHDI), administered by the mutualities. These reimbursements are calculated according to a very complicated system. The care-mix of the institution is of course an important parameter, but it also takes account of the number, qualifications and seniority of the care personnel.[19] The Belfius study calculated above estimates that the total revenue of Flemish residential care institutions for older people from this source was € 1.3 billion in 2013, for a total of 25,890,000 person-days. In addition to the NIHDI reimbursements, these institutions receive substantial funding from other public sources, including subsidies for construction investments from the Flemish Infrastructure Fund for Personal Matters (VIPA) and a number of wage subsidies. In aggregate this amounted to € 550 million in 2013 for the Flemish residential care institutes. Assuming that the personal paid by those subsidies provides care, the average cost of day of care was € 71.46, or € 77.21 when updated to 2015.[20]

However, this average price does not take account of the fact that case 5 is a very dependent person, requiring more care than average. In terms of the care categories used by the NIHDI for residential care, she/he is in category Cd. There are no data on the total or average expenditure per care category. However, we can estimate the average daily care costs of a person in category Cd, using the following equation:

$$TE = \sum_k N_k C_k = \sum_k N_k C_0 w_k \quad (1)$$

where TE is total expenditure, N_k is the number of care days in category *k*, C_k the average cost of a care day of category *k*. The latter can be written as the cost of a day of care in a reference category (C_0) times a weighting factor w_k, reflecting the cost in category *k*, relative to the reference category 0. Provided we have data on TE, N_k and w_k, we can calculate average costs for the reference care category as follows:

$$C_0 = TE / (\sum_k N_k w_k) \quad (2)$$

from which the cost per care category can be computed as $C_k = C_0 w_k$.

The data used are shown in Table 7. The number of days refers to the sample used by the study of the financial accounts quoted. Total revenue from public sources within this sample was € 544 million. The weights w_k are derived from the personnel norms by care category formulated by the NIHDI[21], multiplied by the average salaries of these personnel categories. The result is an estimate of the care cost in category Cd of € 109.56, which updated to 2015 corresponds to € 118.38.

[19] NIHDI, "Verzorging in rustoorden en centra voor dagverzorging", http://www.riziv.fgov.be/nl/professionals/verzorgingsinstellingen/rustoorden/Paginas/default.aspx#Hoe_gebeurt_de_betaling_door_de_ziekteverzekering_aan_de_rustoorden?

[20] Economists and others would note that in fact revenues are used to estimate costs. However, the net profit is only 3.68% of total turnover. Zorgnet Vlaanderen, Financiële analyse - Boekjaren 2010-2013, vzw-woonzorgcentra in Vlaanderen, p. 5. https://www.belfius.be/common/NL/multimedia/MMDownloadableFile/PublicSocial/Expertise/Social_Profit/MARA_2010-2013.pdf downloaded 25-09-2015

[21] In fact; this source does not provide personnel norms for categories Cc and D. We assume that they are the same as for Cd. In any case, the effect of this assumption is small, as categories Cc and D together account for only 2.86% of all care-days.

Table 7 Calculation of residential care cost per care day (2013).

Care category	Number of care days (Nk) (1)	Personnel norm for nursing care	Personnel norm for other care	Personnel norm for reactivation	Personnel norm total (2)	Cost per resident per month	Index cost per patient cat. B = 1 (wk)	Nk * wk	Cost per day
O	543738	0.25			0.25	470	0.049	26655	4.02
A	712089	1.2	0.8		2	1246	0.130	92619	10.66
B	1888779	5	5	1	11	9580	1.000	1888779	81.92
C	919866	5	6	1.5	12.5	12033	1.256	1155466	102.90
Cc	44700	5	6.5	1.5	13	12812	1.337	59783	109.56
Cd	2411107	5	6.5	1.5	13	12812	1.337	3224654	109.56
D	145949	5	6.5	1.5	13	12812	1.337	195195	109.56
Total	6666228								
Reference salaries (3)		56,355	46,725	53,765					

Sources:

(1) Zorgnet Vlaanderen, Financiële analyse - Boekjaren 2010-2013, vzw-woonzorgcentra in Vlaanderen, https://www.belfius.be/common/NL/multimedia/MMDownloadableFile/PublicSocial/Expertise/Social_Profit/MARA_2010-2013.pdf downloaded 25-09-2015

(2) Personnel norms: RIZIV / INAMI Rustoorden voor Bejaarden Rust- en verzorgingstehuizen Nieuw financieringssysteem vanaf 1 januari 2004

(3) J.-M. Rombaux, Maisons de Repos et Maisons de Soins et de Repos, Radioscopie du Secteur Public 2010, Union des Villes et Communes de Wallonie, www.uvcw.be/no_index/cpas/.../radioscopie-2010.pdf

Social protection for care at home

Care packages for personal care at home and home care

Because the kinds of care that the various providers are offering overlap each other, users can choose and compose different care packages for a given need for care (conditional on supply being adequate, of course). For this reason, we compiled several care packages and calculated their costs for the cases 1, 2 and 3, which receive home care. We had to use our own judgment, as well as that of some experts on home care, to choose the package that was the most plausible (in fact the assumption that no informal care is available makes all packages rather implausible).

The care needs as specified in the case descriptions, as well as the care options available for each kind of care, are shown in Table 8, while Table 9 indicates total costs for various package options. Nursing and home care are both appropriate for ADL personal care[22]. However, while nurses can take care of washing and dressing as part of daily care, they are unlikely to help with eating. So we assume that personal home carers will provide this kind of help, even though that is not very likely either.[23] We assume that, when appropriate, nursing care is used, as it is the least costly to the user.[24] IADL care (laundry, cleaning, shopping, preparing food) can be done by home care or by persons paid with service vouchers. Total costs are lower when service vouchers are used, as the hourly price of service voucher work is considerably below that of home care provided by home care organizations (who are presumably better qualified to provide such care). Social activities are part of the task description of additional

[22] The care needs of Case 1 are too low to qualify for reimbursement of nursing care.

[23] Usually, help with eating will be given by an informal carer. If such care is not available, a person with such high care needs will most likely move into residential care.

[24] However, one must keep in mind that the amount of nursing care is not given in hours. Nursing care is reimbursed in fixed amounts per day. It is unclear how many hours nurses will in fact devote to the various care tasks.

home care providers, though it could also be paid for by service vouchers (stretching a bit the list of activities that are allowed with these vouchers).

Table 8 Hours of care per week and care options for typical cases, by kind of care

Kind of care	Case 1: # of hours	Case 1: care options	Case 2: # of hours	Case 2: care options	Case 3: # of hours	Case 3: care options
ADL Personal care, washing, bathing and dressing	2.5	Home care (HCO)	6	Nursing care (HIRN), home care (HCO)	3.75	Nursing care (HIRN), home care (HCO)
ADL personal care, helping with going to bed	-	-	-	-	3.5	Nursing care (HIRN), home care (HCO)
ADL personal care, helping with eating	-	-	-	-	17.5	Home care (HCO)
IADL care	4	Home care (HCO), service vouchers (SV)	14.5	Home care (HCO), service vouchers (SV)	14.5	Home care (HCO), service vouchers (SV)
Social Activity	-	-	2	Additional home care (HCO-A), service vouchers (SV)	2	Additional home care (HCO-A), service vouchers (SV)

Sources: # of hours: specified for each case in OECD questionnaire; care options: author

Table 9 Total costs of packages of care for typical cases, for various package options, per week

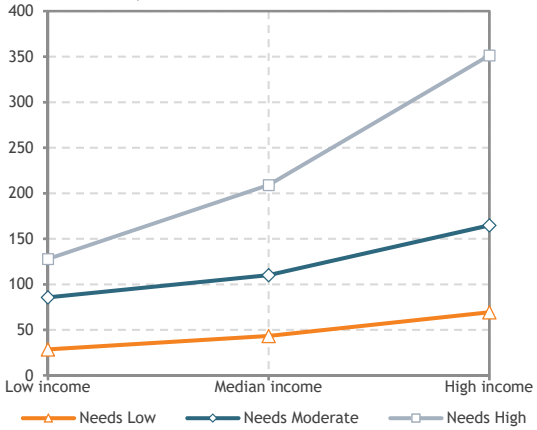
Option	Personal care - washing	Personal care - eating*	IADL care	Social activity	Case 1: Low needs	Case 2: moderate needs	Case 3: High needs
1	HCO	HCO	HCO	SV	243.08	820.72	1602.60
2	HCO	HCO	SV	SV	183.90	606.19	1388.06
3	HIRN	HCO	HCO	HCO-A		738.39	1695.67
4	HIRN	HCO	HCO	SV		714.85	1672.13

Notes: * not relevant for cases 1 and 2. Figures in italics indicate the preferred option for each case

Table 10 presents the costs to the user of the various care packages, by level of needs and income. When appropriate, nursing care is the cheapest option for users. As regards IADL care, home care is generally the cheaper option for care users with low pensions or incomes near the median, while for those with high incomes, service vouchers might be more advantageous. However, the differences in costs between options for the users (given their care needs and income) are in fact not very large. As becomes clear in Figure 2, which shows the cost to users of the preferred care package options, these costs increase both by severity of need and by level of income; note though that these figures do not take into account cash benefits for dependent persons.

Figure 2 **Costs for users of packages of personal and home care for typical cases, by income and severity of need**

In Euro per week



Bron: berekeningen FPB

The public costs shown in Table 11 are the balance of total costs and users' contributions. As a percentage of total costs (Table 12), coverage increases with severity of need and decreases with income. Yet, even for the low needs – high income case, 72 percent of total costs are met by government.

Tabel 10 Costs for users of packages of care for typical cases, for various package options

Option	Personal care washing	Personal care eating*	IADL care	Social activity	Case 1: Low needs; low income	Case 1: Low needs; median income	Case 1: Low needs; high income	Case 2: Moderate needs; low income	Case 2: Moderate needs; median income	Case 2: Moderate needs; high income	Case 3: High needs; low income	Case 3: High needs; median income	Case 3: High needs; high income
1	HCO	HCO	HCO	SV	**28.64**	**43.36**	**69.29**	104.10	151.12	233.98	156.98	251.33	417.61
2	HCO	HCO	SV	SV	36.48	42.28	52.49	132.52	147.21	173.08	199.90	261.91	371.21
3	HIRN	HCO	HCO	HCO-A				**85.68**	**110.16**	**164.77**	**127.83**	**209.06**	**351.42**
4	HIRN	HCO	HCO	SV				77.28	109.62	168.69	131.75	208.52	343.02

Notes: * not relevant for cases 1 and 2. Bold figures indicate the preferred option for each case

Table 11 Public costs (amounts) of packages of care for typical cases, for various package options

Option	Personal care washing	Personal care eating*	IADL care	Social activity	Case 1: Low needs; low income	Case 1: Low needs; median income	Case 1: Low needs; high income	Case 2: Moderate needs; low income	Case 2: Moderate needs; median income	Case 2: Moderate needs; high income	Case 3: High needs; low income	Case 3: High needs; median income	Case 3: High needs; high income
1	HCO	HCO	HCO	SV	**214.44**	**199.72**	**173.79**	716.62	669.60	586.74	1445.62	1351.27	1184.99
2	HCO	HCO	SV	SV	147.42	141.62	131.41	473.66	458.98	433.10	1188.16	1126.15	1016.85
3	HIRN	HCO	HCO	HCO-A				**652.71**	**628.24**	**573.62**	**1567.84**	**1486.61**	**1344.25**
4	HIRN	HCO	HCO	SV				637.57	605.23	546.15	1540.37	1463.60	1329.11

Notes: * not relevant for cases 1 and 2. Bold figures indicate the preferred option for each case

Table 12 Public costs (percentage of total costs) of packages of care for typical cases, for various package options

Option	Personal care washing	Personal care eating*	IADL care	Social activity	Case 1: Low needs; low income	Case 1: Low needs; median income	Case 1: Low needs; high income	Case 2: Moderate needs; low income	Case 2: Moderate needs; median income	Case 2: Moderate needs; high income	Case 3: High needs; low income	Case 3: High needs; median income	Case 3: High needs; high income
1	HCO	HCO	HCO	SV	**88.2%**	**82.2%**	**71.5%**	87.3%	81.6%	71.5%	90.2%	84.3%	73.9%
2	HCO	HCO	SV	SV	80.2%	77.0%	71.5%	78.1%	75.7%	71.4%	85.6%	81.1%	73.3%
3	HIRN	HCO	HCO	HCO-A				**88.4%**	**85.1%**	**77.7%**	**92.5%**	**87.7%**	**79.3%**
4	HIRN	HCO	HCO	SV				89.2%	84.7%	76.4%	92.1%	87.5%	79.5%

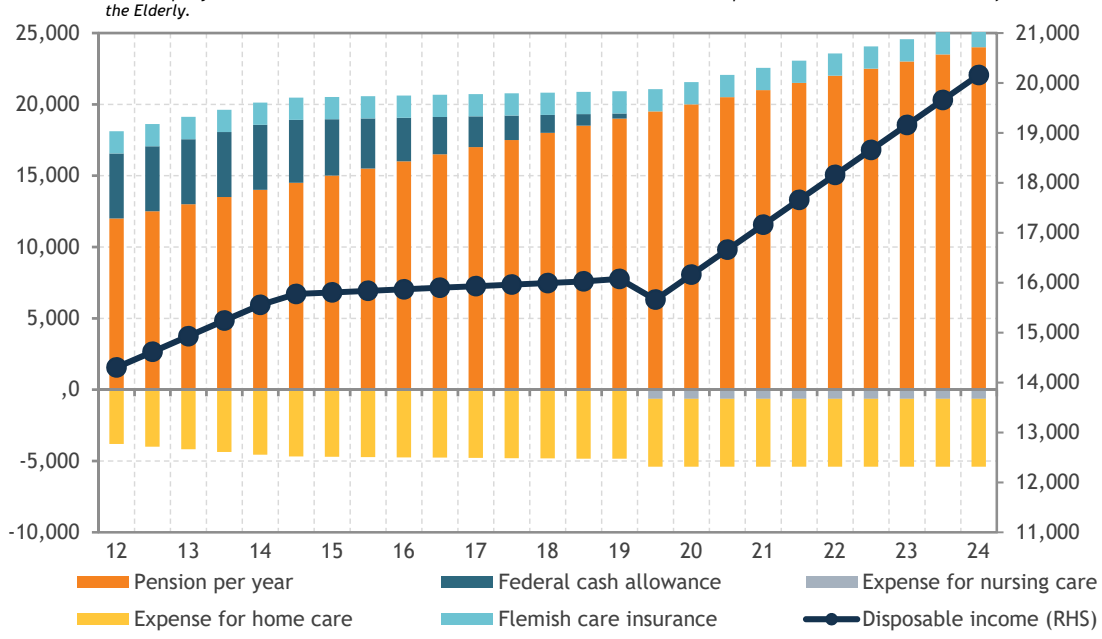
Notes: * not relevant for cases 1 and 2. Bold figures indicate the preferred option for each case

Costs and benefits for dependent using care at home

The data collected on the costs of personal care at home and home care, as well as the information on cash benefits to which dependent persons are entitled, makes it possible to compare the total incomes of single persons with various levels of pensions and a given degree of dependency. This provides an assessment of the joint impact of cash benefits and the costs of care on disposable income, which is here defined as the income left after receiving cash benefits and paying the out-of-pocket costs of care. In Figure 3, which represents the case of a single person with moderate needs, the columns indicate the incomes and costs of a single persons with a certain level of pension, on top of which they receive a care insurance benefit, and an allowance for the assistance of the elderly. Costs are represented by negative bars. The line (right-hand scale) indicates the level of disposable income. Starting from a low pension of € 12,000, disposable income first increases when the pension rises, due to the disregard in the means test of the allowance for the assistance of the elderly. Also, at these low levels of income, benefits exceed costs. When the pension is higher than € 14,000, the mean test starts to bite, and the allowance for the assistance for the elderly tapers off, until the pension reaches € 19,000 per year. When the pension than increases to € 19,500, there is a drop in disposable income, because the person no longer enjoys the status of increased reimbursement, and therefore nursing care becomes considerably more expensive, even though it is still only a fraction of the costs of home care. From that level of pension on, it is assumed that the person switches to service vouchers to pay for home care, because the net price for these is lower than the personal contribution for regular home care. If the person would stick to regular home care, costs would increase with a rising pension, and disposable income would rise less quickly.

Figure 3 **Cash benefits and costs for single older persons with a moderate degree of dependency at various levels of pension**

Amounts per year in 2015. Vertical scale starts at € 10.000. Horizontale axis indicates pension in '000's €. AAE: Allowance for the Assistance of the Elderly.



Sources: See text and own calculations

Conclusion

The aim of the study for which this report is the contribution from Belgium was to assess to what extent the costs of long-term care are covered by social protection systems, using the typical cases approach. Five typical cases have been defined by the OECD in a questionnaire, differing in severity of need (low, moderate and high) and the amount of care received, and also in living situation (single at home with no informal care, at home with informal care, in residential care). In addition, for each case, three income levels were specified.

Both cash benefits and care services provided at less than actual cost within the following schemes were taken into account: the allowance for the assistance of the elderly; the allowances for incontinence and for the chronically ill; the Flemish care insurance; the sickness and invalidity insurance for home nursing care and care in institutions; home care (not nursing care), regulated and subsidized by regional governments; and service vouchers.

Table 13 summarizes the main results from the study for Belgium. (Case 4 is not represented, as the informal care this person receives is assumed to be costless.) A number of things are noteworthy. First of all, the costs of care met directly by the government (through the social health insurance system, subsidies to home care providers and subsidies and tax allowances for service vouchers) far outweigh the cash benefits from the federal and regional governments that are conditional on dependency. Secondly, in all cases most of the total costs of care are borne by the various public systems, from 72% for the low need – high income case to 100% for the high need – low income case. Thirdly, the coverage rate increases with severity of need and decreases with income. The progressivity of the system through means-tested cash benefits and user contributions which increase with income seems to be so strong that in the case of high needs, the person with a high pension ends up less disposable income (after contributions are paid and benefits are received) than those with low and medium pensions.[25] However, this case is rather unrealistic, in that a very high amount of costly home care is used. Persons with such severe needs will either have informal help (reducing strongly the number of hours of paid home care), or, most likely, will have moved to residential care.

[25] In fact, this level of income is below the at-risk-of-poverty threshold.

Table 13 Total costs and benefits for typical cases, by severity of need and income

	Low income	Median income	High income
Case 1: low needs at home			
Total costs of care*	243.08	243.08	243.08
Costs of care met directly by government	214.44	199.72	173.79
Cash benefits	0.00	0.00	0.00
Total value of collective support	214.44	199.72	173.79
Collective support as % of total costs	88.2%	82.2%	71.5%
Net balance borne by user	28.64	43.36	69.29
Pension minus net balance borne by user	227.61	298.93	427.03
Case 2: intermediate needs at home			
Total costs of care*	738.39	738.39	738.39
Costs of care met directly by government	652.71	628.24	573.62
Cash benefits	87.62	27.65	0.00
Total value of collective support	740.33	655.89	573.62
Collective support as % of total costs	100.3%	88.8%	77.7%
Net balance borne by user	-1.94	82.51	164.77
Pension minus net balance borne by user	258.19	259.78	331.55
Case 3: high needs at home			
Total costs of care*	1695.67	1695.67	1695.67
Costs of care met directly by government	1567.84	1486.61	1344.25
Cash benefits	166.21	106.58	39.48
Total value of collective support	1734.05	1593.19	1383.74
Collective support as % of total costs	102.3%	94.0%	81.6%
Net balance borne by user	-38.38	102.48	311.94
Pension minus net balance borne by user	294.63	239.81	184.38
Case 5: high needs in residential care			
Total costs	1194.04	1194.04	1194.04
Costs of care met directly by government	828.64	828.64	828.64
Cash benefits	156.73	97.10	30.00
Total value of collective support	985.37	925.74	858.64
Collective support as % of total costs	82.5%	77.5%	71.9%
Net balance borne by user	208.67	268.30	335.40
Pension minus net balance borne by user	47.58	73.99	160.92

The study has a number of limitations. First of all, the typical cases living at home are unrealistic, as it is unlikely, especially for cases 2 and 3, that they get no informal care at all. Therefore, the amount of formal care received is most likely exaggerated compared with actual usage patterns. Second, the typical cases are assumed to live in Flanders. Older persons living in Wallonia cannot receive a benefit from the Flemish care insurance system[26]. Home care may be cheaper or costlier for users in that region than

[26] People living in the Capital Region of Brussels can voluntarily join this scheme.

in Flanders. Third, benefits and services provided by municipalities and mutualities are disregarded. Fourth, on the other hand, costs related to disability and health care other than those for long-term care are also disregarded.

Appendix: OECD Questionnaire

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
Health and Social Policy Divisions

EUROPEAN COMMISSION

DG Employment, Social Affairs
and Inclusion
Europe 2020: Social Policies

Measuring social protection for older people with long-term care needs

Data collection questionnaire

Country: Belgium

Please read the attached notes before completing this questionnaire
If you have any questions, please contact Tim Muir at the OECD (tim.muir@oecd.org)

BACKGROUND INFORMATION

General information about support for people with long-term care needs in your country has previously been collected for the MISSOC database (the Mutual Information System on Social Protection), so this questionnaire won't ask for the same information again.

However, we do need you to confirm some details that we have derived from the MISSOC data, provide us with the typical cost of services in your country and check the income data that we are using. These pieces of information will be important for the main part of the questionnaire, which will provide descriptions of typical people with long-term care needs and ask about the support they would receive in your country.

The following definitions are important in answering the questions below (more details are in the attached guidance)

> *"Long-term care" refers to the services required to meet people's ADL, IADL and social needs*
> *Where relevant you should assume that we are talking about older people (over 65) who have developed care needs through a deterioration of physical and/or mental function in old age, rather than through any specific illness or injury.*

1. Schemes that provide collective support for people with long-term care needs

In order to answer this questionnaire you will need to define which collective support schemes in your country are relevant to long-term care. These are the schemes that would provide support to an older person with long-term care needs but would not provide support to an equivalent person without long-term care needs (see attached guidance for more details). If your health system routinely provides long-term care services, as defined here, then you should include it in your answers.

We've provided our best guess below based on the MISSOC data, but please verify and provide any corrections in the box below. Please include the name of the scheme, an English translation and a one-line description.

These are the schemes you should consider when calculating levels of support for the typical cases defined in this questionnaire.

Our best guess from MISSOC (corrected by country informant)

Sickness and invalidity insurance
Pays part of the cost of care services for dependent people, both at home and in institutions

Care insurance (Flanders only)
A flat rate cash benefit paid to people with care needs

Allowance for the assistance of the elderly
A cash allowance with five levels of payment, income and assets – dependent

Incontinence Allowance

Federal Allowance for the costs of incontinence for severely incontinent persons not in residential care

Home care (not nursing care)
Subsidized home care (except nursing care), provided by private organizations, prices are regulated by Regional government, in Flanders income-dependent

Service vouchers
Tax-subsidized vouchers for household tasks

Your comments and corrections

Integration allowance is for non-aged persons only.

2. Hourly cost of care services

Please provide a typical hourly cost for different types of care services. You should use these costs to calculate the total cost of the care packages described in each typical case (unless you prefer to calculate the total costs in another way).

If the cost of services is subsidised, please provide the unsubsidised cost here if possible. The value of the subsidy should be included in the level of collective support that you provide for each typical case.

ADL needs	€ See report
IADL needs	€ See report
Social needs	€ See report

3. Typical incomes of older people (over 65)

The questionnaire will ask you how much support people with different levels of income will get. We have used OECD, EU and other data to estimate the level of income that a typical older person has in your country (median), as well as a high-income case (80th percentile) and a low-income case (20th percentile).

These estimates are for income after taxes and transfers – i.e. the disposable income that a person has to spend each week. For the purposes of this questionnaire, you should assume that this represents the weekly income that this person would have if they didn't have a long-term care need. Any additional income that they receive as a result of the long-term care need should be included in your answers under each typical case.

These numbers may not precisely match your own estimates, because we have used the same source and methodology for all countries. However, if these numbers are significantly different to your own, then please contact Tim Muir at the OECD (tim.muir@oecd.org).

Low income (20th percentile)	€ 256.25 per week
Median income	€ 342.29 per week
High income (80th percentile)	€ 496.32 per week

Your comments

OK. Low income is a bit above the guaranteed minimum income for older people (IGO), which is 233.46 EUR per week

3. Any other comments

Use this space to provide any other comments that you think are relevant, but aren't covered by the other questions. You can also send us separate documents alongside this questionnaire, or get in touch with us to discuss any issues.

See separate document

TYPICAL CASE 1

HOME CARE FOR LOW NEEDS

Description of needs	
ADL needs	**Mobility** Can get in and out of bed independently. Has limited movement of the torso and problems bending down. Can walk slowly in the home without a mobility aid and stand without the risk of falling. Can leave the house without help and go for short walks using a walking frame. Can travel independently to see a doctor. **Hygiene** Can dress and undress independently, although this is slow and requires significant effort, especially for dressing the bottom half of the body. Needs help to get in and out of the bathtub. Can wash face and upper part of the body with assistance, but back and lower part of the body need to be washed by caregiver. Can comb hair and brush teeth under supervision. Has full bladder and bowel control, can use toilet independently and can clean self after defaecation. **Food intake** Can cut food into pieces and independently consume food and drinks. *Barthel Index score: 17/20*
IADL needs	**Shopping:** can go to supermarket independently but cannot carry heavy shopping bags **Cooking:** can prepare simple meals and arrange delivery of meals-on-wheels (the cost of these meals should not be included in your answers) **Cleaning:** can do simple housework (e.g. cleaning surfaces) but nothing that requires lifting or bending (e.g. vacuuming the floor) **Laundry:** cannot do any laundry *Lawton IADL score: 6/8*
Social needs	This person is able to maintain social activities independently
Other details	None of the above needs can be met through informal care. If relevant, assume that this person lives alone.

Description of services provided by professional caregiver *Except where <u>support</u> or <u>supervise</u> is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 20 minutes, six times a week <u>Supervise</u> patient to undress and dress again <u>Support</u> patient to wash the upper part of the body <u>Supervise</u> hair care, combing Wash the lower part of the patient's body and back Cleaning of care area **Bathing and dressing** 30 minutes, once a week <u>Support</u> patient to undress and dress again <u>Support</u> patient to get into the bathtub <u>Support</u> patient to wash the upper part of the body Wash the lower part of the patient's body and back <u>Supervise</u> hair care, combing Cleaning of care area

	2 hours 30 minutes per week
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour of support, twice a week *4 hours per week*
Social needs	None

Weekly cost of care services for this person		
	Calculated from your hourly costs	*Or provide an alternative value*
ADL needs	2½ hours x hourly cost = € 0.00	€ 95.74
IADL needs	4 hours x hourly cost = € 0.00	€ 147.34
Social needs	None	None
Total cost	**€ 243.08**	
Comments	Assuming all care is provided by home care organization.	

Total value of collective support available to a person with these needs and different levels of income *This should be the total value of collective support from all of the systems that you identified in the first section of the questionnaire.*		
	If they have low assets *below any relevant threshold*	If they have high assets *above any relevant threshold*
Low income (20th percentile) *€ 256.25 per week*	**€ 214.44**	**€ 214.44**
Median income for over-65s *€ 342.29 per week*	**€ 199.72**	**€ 199.72**
High income (80th percentile) *€ 496.32 per week*	**€ 173.79**	**€ 173.79**

Other questions about this case	
How would this person score on any relevant assessment systems? *e.g. high, medium or low need, a number of points, a need category etc.*	BEL-scale (0-75): **13** (below threshold for benefit) "Autonomy scale" (0-18): **6** (below threshold for federal allowance Katz scale (used by NIHDI): no score
Please describe how the level of collective support is calculated in this case. Where the person receives support from more than one system, please include all relevant systems if possible.	No cash benefit, only home care by home care organization, subsidized by the Flemish government. See excel sheet and separate document for details.
Would a different set of care services to that described above commonly be provided to a person with these needs? If so, please describe.	Hard to say, depends much on local circumstances
Where the cost of formal services is not covered in full by collective support, what would be the most likely outcome? *i.e. would the person pay privately, go without care, or something else?*	????
Please provide any other relevant information.	

TYPICAL CASE 2

HOME CARE FOR MODERATE NEEDS

Description of needs	
ADL needs	**Mobility** Can get in and out of bed independently. Has limited movement of the torso and problems bending down. Can walk around the home only with the use of a mobility aid, but is unable to climb stairs unaided. Can transfer independently in and out of bed, chairs and toilets using grab rails, which are installed in the home (the cost of these adaptations should not be considered for this questionnaire). Can leave the house and go for short walks only with assistance and the use of a walking frame. Needs a wheelchair to travel longer distances or remain out of the house for a long time. Can travel to see a doctor if accompanied by caregiver. **Hygiene** Requires assistance to dress and undress. Needs help to get in and out of the bathtub. Can wash face with assistance, but back and upper and lower parts of the body need to be washed by caregiver. Can comb hair and brush teeth under supervision. Has bowel control, can use toilet independently using grab rails which are installed, and can clean self after defaecation. Has limited bladder control and wears pads which need to be changed twice a day. **Food intake** Can cut food into pieces and independently consume food and drinks. *Barthel Index score: 11/20*
IADL needs	**Shopping:** can go to local shops with assistance but cannot carry shopping bags **Cooking:** cannot prepare food **Cleaning:** cannot do any housework or cleaning **Laundry:** cannot do any laundry *Lawton IADL score: 4/8*
Social needs	Unable to maintain any social activities without assistance
Other details	None of the above needs can be met through informal care. All necessary home adaptations have been installed and the cost of these adaptations is not in scope for this project.

Description of services provided by professional caregiver *Except where support or supervise is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 20 minutes, six times a week Support patient to undress and dress again Support patient in washing face Supervise hair care, combing Washing the patient's upper body, back and lower body Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Bathing and dressing** 30 minutes, once a week Support patient to undress and dress again Support patient to get into the bathtub Support patient in washing face Washing the patient's upper body, back and lower body Supervise hair care, combing Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Incontinence management** 15 minutes twice a day Application of new sanitary pads, removal and disposal of used ones *6 hours per week*
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour, twice a week **Prepare meals** 1 hour 30 minutes per day in total *14 hours 30 minutes per week*
Social needs	**Social activity** 2 hours per week (e.g. caregiver takes the patient for two one-hour walks)

Weekly cost of care services for this person		
	Calculated from your hourly costs	*Or provide an alternative value*
ADL needs	6 hours x hourly cost = € 0.00	€ 136.65
IADL needs	14½ hours x hourly cost = € 0.00	€ 534.12
Social needs	2 hours x hourly cost = € 0.00	€ 67.33
Total cost	**€ 738.39**	
Comments	See Excel sheet. NIHDI nursing care for ADL-needs, home care for IADL needs, service vouchers for social needs.	

Total value of collective support available to a person with these needs and different levels of income *This should be the total value of collective support from all of the systems that you identified in the first section of the questionnaire.*		
	If they have low assets *below any relevant threshold*	If they have high assets *above any relevant threshold*
Low income (20th percentile) *€ 256.25 per week*	€ 740.33	€ 652.71
Median income for over-65s *€ 342.29 per week*	€ 655.89	€ 628.24
High income (80th percentile) *€ 496.32 per week*	€ 564.96	€ 564.96

Other questions about this case	
How would this person score on any relevant assessment systems? *e.g. high, medium or low need, a number of points, a need category etc.*	BEL-scale (0-75): **25** (below threshold for benefit) "Autonomy scale" (0-18): **12** (Category 3 for federal allowance Katz scale (used by NIHDI): **A**
Please describe how the level of collective support is calculated in this case. Where the person receives support from more than one system, please include all relevant systems if possible.	Federal allowance; no Flemish care insurance benefit. NIHDI nursing care for ADL-needs, home care for IADL needs, additional home care for social needs.
Would a different set of care services to that described above commonly be provided to a person with these needs? If so, please describe.	Hard to say, depends much on local circumstances
Where the cost of formal services is not covered in full by collective support, what would be the most likely outcome? *i.e. would the person pay privately, go without care, or something else?*	????
Please provide any other relevant information.	

TYPICAL CASE 3

HOME CARE FOR HIGH NEEDS

Description of needs	
ADL needs	**Mobility** Cannot get up or go to bed independently. Needs to be lifted manually into/out of the bed and positioned in bed. Can sit independently and has limited use of arms. Can stand when holding onto a person or object only for short periods of time before losing balance and falling. Can only make one or two steps before losing balance even when holding on to a person or object, so is put in a wheelchair for most time of the day. Cannot move the wheelchair but needs to be moved everywhere within the apartment or outside the apartment by a caregiver. Can travel as a passenger when lifted into car/ taxi when accompanied by a caregiver. Cannot travel regularly to see a doctor, so requires home visits (the cost of these is out of scope of this questionnaire). **Hygiene** Cannot dress and undress independently. This needs to be completely done by the caregiver with the patient sitting on the bed or bathtub. Needs to be lifted in and out of the bathtub which is done manually. Can only wash face with some difficulties and some assistance. Upper part, back and lower part of the body need to be washed by the caregiver. Needs support when combing hair or brushing teeth. Has bowel control but needs to be lifted from wheelchair to toilet and cleaned after defaecation; has limited bladder control and wears pads which need to be changed twice a day. **Food intake** Cannot cut food into pieces but can move food and drink (with straw) to own mouth under supervision. *Barthel Index score: 4/20*
IADL needs	**Shopping:** cannot do any shopping **Cooking:** cannot prepare food **Cleaning:** cannot do any housework or cleaning **Laundry:** cannot do any laundry **Other:** unable to use the telephone or manage money without assistance *Lawton IADL score: 0/8*
Social needs	Unable to maintain any social activities without assistance
Other details	Also requires significant healthcare, but this is outside the scope of the project Has advanced dementia and displays hoarding behaviours and agitated or aggressive behaviours, such as shouting or hitting out Lives with a spouse who can provide 24-hour supervision, help with taking medicines, and manage the finances but cannot provide any other ADL/IADL care.

Description of services provided by professional caregiver *Except where <u>support</u> or <u>supervise</u> is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 30 minutes, six days a week Transfer out of bed, lifting patient into wheelchair <u>Support</u> patient to undress and dress again <u>Support</u> patient in washing face Washing the patient's upper body, back and lower body <u>Support</u> patient in hair care, combing <u>Support</u> to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Bathing and dressing** 45 minutes, once a week Transfer out of bed, lifting patient into wheelchair <u>Support</u> patient to undress and dress again Lifting patient in bathtub <u>Support</u> patient in washing face Washing the patient's upper body, back and lower body <u>Support</u> patient in hair care, combing <u>Support</u> to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Help with feeding** 50 minutes daily, three times a day Cutting of food to mouth pieces <u>Supervise</u> food intake Moving patient to table Providing drinks Disposal of material Cleaning of work space **Going to bed** 30 minutes daily <u>Support</u> patient to undress and dress again Helping patient to transfer into bed and positioning of person in bed <u>Support</u> to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) Application of new sanitary pads, removal and disposal of used ones *24 hours 45 minutes per week*
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour, twice a week **Prepare meals** 1 hour 30 minutes per day in total *14 hours 30 minutes per week*
Social needs	**Social activity** 2 hours per week (e.g. caregiver takes the patient for two one-hour walks)

Weekly cost of care services for this person		
	Calculated from your hourly costs	*Or provide an alternative value*
ADL needs	24¾ hours x hourly cost = € 0.00	€ 1093.93
IADL needs	14½ hours x hourly cost = € 0.00	€ 534.12
Social needs	2 hours x hourly cost = € 0.00	€ 67.33
Total cost	**€ 1695.67**	
Comments	See Excel sheet, option 5. Some personal care (washing, dressing, bathing, going to bed) provided by NIHDI reimbursed nurse; other personal care (eating) & IADL care by home care organization; social activity by additional home care.	

Total value of collective support available to a person with these needs and different levels of income *This should be the total value of collective support from all of the systems that you identified in the first section of the questionnaire.*		
	If they have low assets *below any relevant threshold*	If they have high assets *above any relevant threshold*
Low income (20th percentile) *€ 256.25 per week*	€ 1721.73	€ 1595.00
Median income for over-65s *€ 342.29 per week*	€ 1593.19	€ 1526.09
High income (80th percentile) *€ 496.32 per week*	€ 1384.51	€ 1384.51

Other questions about this case	
How would this person score on any relevant assessment systems? *e.g. high, medium or low need, a number of points, a need category etc.*	BEL-scale (0-75): **52** (above threshold for benefit) "Autonomy scale" (0-18): **17** (Category 5 for federal allowance Katz scale (used by NIHDI): **C**
Please describe how the level of collective support is calculated in this case. Where the person receives support from more than one system, please include all relevant systems if possible.	Federal allowance: maximum amount for low-income person, 0 when high assets; Incontinence allowance; Flemish care insurance benefit. Some personal care (washing, dressing, bathing, going to bed) provided by NIHDI reimbursed nurse; other personal care (eating) & IADL care by home care organization; social activity by additional home care...
Would a different set of care services to that described above commonly be provided to a person with these needs? If so, please describe.	It is unlikely that help with eating would be provided. If a person with high needs has no partner or other informal cared in the household, he/she would probably go to a nursing home.

Where the cost of formal services is not covered in full by collective support, what would be the most likely outcome? *i.e. would the person pay privately, go without care, or something else?*	????
Please provide any other relevant information.	

TYPICAL CASE 4

INFORMAL CARE FOR MODERATE NEEDS

This person has the same needs as typical case 2, but they are met by an informal carer rather than a professional carer.

Description of needs	
ADL needs	**Mobility** Can get in and out of bed independently. Has limited movement of the torso and problems bending down. Can walk around the home only with the use of a mobility aid, but is unable to climb stairs unaided. Can transfer independently in and out of bed, chairs and toilets using grab rails, which are installed in the home (the cost of these adaptations should not be considered for this questionnaire). Can leave the house and go for short walks only with assistance and the use of a walking frame. Needs a wheelchair to travel longer distances or remain out of the house for a long time. Can travel to see a doctor if accompanied by caregiver. **Hygiene** Requires assistance to dress and undress. Needs help to get in and out of the bathtub. Can wash face with assistance, but back and upper and lower parts of the body need to be washed by caregiver. Can comb hair and brush teeth under supervision. Has bowel control, can use toilet independently using grab rails which are installed, and can clean self after defaecation. Has limited bladder control and wears pads which need to be changed twice a day. **Food intake** Can cut food into pieces and independently consume food and drinks. *Barthel Index score: 11/20*
IADL needs	**Shopping:** can go to local shops with assistance but cannot carry shopping bags **Cooking:** cannot prepare food **Cleaning:** cannot do any housework or cleaning **Laundry:** cannot do any laundry *Lawton IADL score: 4/8*
Social needs	Unable to maintain any social activities without assistance
Other details	None of the above needs can be met through informal care. All necessary home adaptations have been installed and the cost of these adaptations is not in scope for this project.

Description of services that would be required if needs were met professionally – the informal caregiver meets all of the person's needs, either by providing these services or in another way *Except where support or supervise is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 20 minutes, six times a week Support patient to undress and dress again Support patient in washing face Supervise hair care, combing Washing the patient's upper body, back and lower body

	Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Bathing and dressing** 30 minutes, once a week Support patient to undress and dress again Support patient to get into the bathtub Support patient in washing face Washing the patient's upper body, back and lower body Supervise hair care, combing Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Incontinence management** 15 minutes twice a day Application of new sanitary pads, removal and disposal of used ones *6 hours per week*
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour, twice a week **Prepare meals** 1 hour 30 minutes per day in total *14 hours 30 minutes per week*
Social needs	**Social activity** 2 hours per week (e.g. caregiver takes the patient for two one-hour walks)

Weekly cost of care services for this person
All needs are met through informal care, which is provided by the person's family, so there is no out-of-pocket cost in this case.

Total value of collective support available to a person with these needs and different levels of income
This should be the total value of collective support from all of the systems that you identified in the first section of the questionnaire. If the person does not receive any support because the needs are met informally, then answer zero in all cases.

	If they have low assets *below any relevant threshold*	If they have high assets *above any relevant threshold*
Low income (20th percentile) *€ 256.25 per week*	€ 87.62	€ 0.00
Median income for over-65s *€ 342.29 per week*	€ 27.65	€ 0.00
High income (80th percentile) *€ 496.32 per week*	€ 0.00	€ 0.00

Other questions about this case	
How would this person score on any relevant assessment systems? *e.g. high, medium or low need, a number of points, a need category etc.*	BEL-scale (0-75): **25** (below threshold for benefit) "Autonomy scale" (0-18): **12** (Category 3 for federal allowance Katz scale (used by NIHDI): **A**
Please describe how the level of collective support is calculated in this case. Where the person receives support from more than one system, please include all relevant systems if possible.	Federal allowance; no Flemish care insurance benefit...
Please give details of any cash or in-kind benefits that would be available to the carer in this case.	Some communities provide an allowance for informal carers, though this tends to have been cut back in recent years. It was seldom more than 30-50 Euros per month.
Please provide any other relevant information.	

TYPICAL CASE 5

INSTITUTIONAL CARE FOR HIGH NEEDS

This person has the same needs as typical case 3, but they are met in an institution instead of in the community.

Description of needs	
ADL needs	**Mobility** Cannot get up or go to bed independently. Needs to be lifted manually into/out of the bed and positioned in bed Can sit independently and has limited use of arms. Can stand when holding onto a person or object only for short periods of time before losing balance and falling. Can only make one or two steps before losing balance even when holding on to a person or object, so is put in a wheelchair for most time of the day. Cannot move the wheelchair but needs to be moved everywhere within the apartment or outside the apartment by a caregiver. Can travel as a passenger when lifted into car/ taxi when accompanied by a caregiver. Cannot travel regularly to see a doctor, so requires home visits (the cost of these is out of scope of this questionnaire). **Hygiene** Cannot dress and undress independently. This needs to be completely done by the caregiver with the patient sitting on the bed or bathtub. Needs to be lifted in and out of the bathtub which is done manually. Can only wash face with some difficulties and some assistance. Upper part, back and lower part of the body need to be washed by the caregiver. Needs support when combing hair or brushing teeth. Has bowel control but needs to be lifted from wheelchair to toilet and cleaned after defaecation; has limited bladder control and wears pads which need to be changed twice a day. **Food intake** Cannot cut food into pieces but can move food and drink (with straw) to own mouth under supervision. *Barthel Index score: 4/20*
IADL needs	**Shopping:** cannot do any shopping **Cooking:** cannot prepare food **Cleaning:** cannot do any housework or cleaning **Laundry:** cannot do any laundry **Other:** unable to use the telephone or manage money without assistance *Lawton IADL score: 0/8*
Social needs	Unable to maintain any social activities without assistance
Other details	Also requires significant healthcare, but this is outside the scope of the project Has advanced dementia and displays hoarding behaviours and agitated or aggressive behaviours, such as shouting or hitting out Requires 24-hour supervision.

Description of services provided within the institution and approximate timings where relevant *Except where <u>support</u> or <u>supervise</u> is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 30 minutes, six days a week Transfer out of bed, lifting patient into wheelchair <u>Support</u> patient to undress and dress again <u>Support</u> patient in washing face Washing the patient's upper body, back and lower body <u>Support</u> patient in hair care, combing <u>Support</u> to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Bathing and dressing** 45 minutes, once a week Transfer out of bed, lifting patient into wheelchair <u>Support</u> patient to undress and dress again Lifting patient in bathtub <u>Support</u> patient in washing face Washing the patient's upper body, back and lower body <u>Support</u> patient in hair care, combing <u>Support</u> to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) Application of new sanitary pads, removal and disposal of used ones Cleaning of care area **Help with feeding** 50 minutes daily, three times a day Cutting of food to mouth pieces <u>Supervise</u> food intake Moving patient to table Providing drinks Disposal of material Cleaning of work space **Going to bed** 30 minutes daily <u>Support</u> patient to undress and dress again Helping patient to transfer into bed and positioning of person in bed <u>Support</u> to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) Application of new sanitary pads, removal and disposal of used ones *24 hours 45 minutes per week*
IADL needs	*The following services are provided by the institution to all residents, so it is not possible to assign an amount of professional carer time for a single person.* **Laundry** **Cleaning** **Preparing and serving all meals** *The following services are provided directly to the individual on a one-to-one-basis* **Finances** 20 minutes, once a week **Help taking medications** 15 minutes daily
Social needs	The institution organises regular social activities for residents

Weekly cost of care services for this person	
Total cost of the institution	€ 1194.04
Of which care costs (if available)	€ 828.64
Of which accommodation costs (if available)	€ 365.40
Comments	Accomodation cost for one-person room adapted to demented persons in home "Kempenerf" in Dessel. Each home sets its own accomodation price. "Kempenerf" appears to be below average. Care costs is – in a nutshell – an estimate of sum of public reimbursements and subsidies that residential receive, divided by the total number of person-days in residential care, and adapted to the higher personnel needs of a persons with high care needs with dementia (category Cd on the NIHDI-scale); see text of accompanying document for details.

Total value of collective support available to a person with these needs and different levels of income *This should be the total value of collective support from all of the systems that you identified in the first section of the questionnaire.*		
	If they have low assets *below any relevant threshold*	If they have high assets *above any relevant threshold*
Low income (20th percentile) *€ 256.25 per week*	€ 985.37	€ 858.64
Median income for over-65s *€ 342.29 per week*	€ 925.74	€ 858.64
High income (80th percentile) *€ 496.32 per week*	€ 858.64	€ 858.64

Other questions about this case	
How would this person score on any relevant assessment systems? *e.g. high, medium or low need, a number of points, a need category etc.*	BEL-scale (0-75): **52** (above threshold for benefit) "Autonomy scale" (0-18): **17** (Category 5 for federal allowance Katz scale (used by NIHDI): **C**
Please describe how the level of collective support is calculated in this case. Where the person receives support from more than one system, please include all relevant systems if possible.	Federal allowance (maximum); Flemish care insurance benefit. See separate document for details about the determination of care costs has been derived.
Would a different set of care services to that described above commonly be provided to a person with these needs? If so,	See Typical case 3

please describe. *e.g. if this person would not be in institutional care in your country*	
Where the cost of formal services is not covered in full by collective support, what would be the most likely outcome? *i.e. would the person pay privately, go without care, or something else?*	????
Please provide any other relevant information.	