Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Belgium

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Content

Main Findings

Overview for representative organization of family carers and older people

- There is no evidence for a change in the willingness of families to care, but there are changes in the availability of family members for providing care. Families are smaller, more women participate in the labour market and the mobility of families has increased. All these evolutions leave less family members nearby to care. Nevertheless, there is a strong trend for the government to promote family care. To this end, the government has established a number of financial and other stimuli.
- Quite an extensive number of measures to facilitate the combination of work and care have been established in recent years, allowing family members to suspend work part-time or full-time for a certain period, in order to be able to give care. However, much still depends on the willingness of the employer and on the financial possibilities of the caregiver, since the financial compensations are either rather low or non-existing. The social statute for the carer, which for long has been demanded by organizations of family carers, still has not been established.
- The offer of services for family carers has grown considerably over the years. There are possibilities for counselling, for needs assessment, for temporary relief of care (respite care, granny-sitting, weekend breaks, et cetera). However, there is a lack of special services for different ethnic groups.
- The primary health care sector is very well developed. However, the personal contributions to be paid can be quite a burden, especially if someone needs a lot of care. Home care thus still proves to be more expensive than hospital care (at least for the family). The government has and is trying to counter this with – among other things – the 'maximum invoice' system. This all the more important for elderly people, since research shows that they are major users of primary health care.
- The number of geriatric ward beds in hospitals has been decreased over the years. Yet, giving the ageing foreseeable in the future, more elderly people will need hospitalization. This could lead to a gap between the number of bed needed and the number of beds available. Also, the number of geriatricians is relatively low.
- Palliative care is well provided at home as well as in (specialized wards) of hospitals.

- The involvement of carers in hospital care and in nursing home care heavily depends on the policy of the hospital or the nursing home in question. This is a point that needs to be worked upon.
- Residential care is still an essential part of the caring process for elderly people. Not everybody can be cared for at home. The quality of nursing home care is being monitored and on average is good to excellent. However, many nursing homes have waiting lists, especially those that have special wards for people suffering from dementia. Moreover, although income is not a criterion for admission – everybody will find a place – residential care for elderly people is expensive. The gap between the average pension and the average price for a room in a nursing home is still getting better. This might prevent elderly people and their caregivers to apply for a room, even if this would be for the better for both parties.
- There is also a large offer of community care services, although there are regional differences in availability. Also, some services have (long) waiting lists. There is a clear need for an expansion of the offer, certainly if we consider the fact that the number of people in need of help will grow considerably over the next decades.
- The federal government offers compensations to elderly people for diminished or lack of ability to do things independently. The amount depends on the income of the dependent person and the person(s) her or she forms a household with. The money can be used to pay an informal carer. Also, in Flanders and Brussels, the care insurance provides compensations for non-medical costs for dependent people. Family care is among those costs. Some local authorities give extra compensations to people caring for a family member at home.
- There still are quite substantive differences between different regions, and even between local municipalities. Family caregivers and those in need of care thus do not have equal rights all over the country.
- Carer abuse has become an issue since 1998. Since then, Central Report Points for Elderly Abuse have been established.
- The main issues for representative organizations of family carers and older people seem to be the social statute of the family carer and the affordability of care.

Overview for service providers

- There is no evidence for a change in the willingness of families to care, but there are changes in the availability of family members for providing care. Families are smaller, more women participate in the labour market and the mobility of families has increased. All these evolutions leave less family members nearby to care. Nevertheless, there is a strong trend for the

government to promote family care. This leads to the conclusion that family care has and will have to be supported by formal services at home. If not, families will not be able to keep on caring.

- Quite an extensive number of measures to facilitate the combination of work and care have been established in recent years, allowing family members to suspend work part-time or full-time for a certain period, in order to be able to give care. However, much still depends on the willingness of the employer and on the financial possibilities of the caregiver, since the financial compensations are either rather low or non-existing. The social statute for the carer, which for long has been demanded by organizations of family carers, still has not been established.
- The offer of services for family carers has grown considerably over the years. There are possibilities for counselling, for needs assessment, for temporary relief of care (respite care, granny-sitting, weekend breaks, et cetera). However, there is a lack of special services for different ethnic groups.
- The primary health care sector is very well developed. However, the personal contributions to be paid can be quite a burden, especially if someone needs a lot of care. Home care thus still proves to be more expensive than hospital care (at least for the family). The government has and is trying to counter this with – among other things – the 'maximum invoice' system. This all the more important for elderly people, since research shows that they are major users of primary health care.
- The number of geriatric ward beds in hospitals has been decreased over the years. Yet, giving the ageing foreseeable in the future, more elderly people will need hospitalization. This could lead to a gap between the number of bed needed and the number of beds available. Also, the number of geriatricians is relatively low.
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- The involvement of carers in hospital care and in nursing home care heavily depends on the policy of the hospital or the nursing home in question. This is a point that needs to be worked upon.
- Residential care is still an essential part of the caring process for elderly people. Not everybody can be cared for at home. The quality of nursing home care is being monitored and on average is good to excellent. However, many nursing homes have waiting lists, especially those that have special wards for people suffering from dementia. Moreover, although income is not a criterion for admission – everybody will find a place – residential care for elderly people is expensive. The gap between the average pension and the average price for a room in a nursing home is

still getting better. This might prevent elderly people and their caregivers to apply for a room, even if this would be for the better for both parties.

- There is also a large offer of community care services, although there are regional differences in availability. Also, some services have (long) waiting lists. There is a clear need for an expansion of the offer, certainly if we consider the fact that the number of people in need of help will grow considerably over the next decades.
- The federal government offers compensations to elderly people for diminished or lack of ability to do things independently. The amount depends on the income of the dependent person and the person(s) her or she forms a household with. The money can be used to pay an informal carer as well as for formal care. Also, in Flanders and Brussels, the care insurance provides compensations for non-medical costs for dependent people. The personal contributions for community care services are among those costs. Some local authorities give extra compensations to people caring for a family member at home.
- There still are quite substantive differences between different regions, and even between local municipalities in the availability of services and in the financial compensations offered to families. Family caregivers and those in need of care thus do not have equal rights all over the country.
- Carer abuse has become an issue since 1998. Since then, Central Report Points for Elderly Abuse have been established.
- One of the main issues for service providers seems to be the integration of different services for home care – all too often, services work separately, the establishment of the GDTs and SITs / SELs should help to cover this problem.
- Another major issue is the reduction of the waiting lists for certain services in certain regions. If government wants to promote in-home care further, service providers will need more finances to extend the number of services they provide.
- Service providers, along with the government, will also have to stimulate people to become nurses and formal carers. At this moment, they experience difficulties in finding sufficient and good personnel.
- It is unclear whether elderly people and their families have sufficient knowledge about the services that are available to them.

Overview for policy makers

- There is no evidence for a change in the willingness of families to care, but there are changes in the availability of family members for providing care. Families are smaller, more women participate in the labour market and the

mobility of families has increased. All these evolutions leave less family members nearby to care. Nevertheless, there is a strong trend for the government to promote family care. To this end, the government has established a number of financial and other stimuli. These should certainly be evaluated positively, but they might still be insufficient if we consider the growth in the elderly population in the next decades.

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- There still are quite substantive differences between different regions, and even between local municipalities. Family caregivers and those in need of care thus do not have equal rights all over the country.
- Carer abuse has become an issue since 1998. Since then, Central Report Points for Elderly Abuse have been established.
- The affordability of care and of pensions is and will be a major issue for policy makers. In order to keep on providing sufficient and good quality of care as the population grows older, major investments will have to be made. The elderly and the problems the elderly are confronted with should be a policy priority. Based on the percentage of the national budget spent in that area at this moment, we cannot say that this is as yet the case.

Introduction – An Overview on Family Care

The family network available for caring has – as in the case in many European countries – become smaller because of lower birth rates, high life expectancy and an increased female participation in the labour market. The 'babyboom'-generation now becoming older, has less children and the children usually do not live as close to their parent's home as was the case a few decades ago. There is no indication that the number of births will raise again (see Table 30 in Appendix). Life expectancy still is increasing (see Tables 31 and 32 in Appendix). For example, in 1990 there were 546 people aged 100 years or older in Belgium. In 2003 there were 1.154 (N.I.S., http://www.statbel.fgov.be/figures/d21_nl.asp#4). Also, within the group of people older than 60 years of age, the proportion of the number of people older than 80 years of age is increasing.

The family network is still very important where caring is concerned. Grandparents care for grandchildren while their parents are at work, and children take care of parent when they get older. Also spouses care for each other. The government very much promotes family care. Nevertheless, the family network has become and is getting smaller.

There are major regional differences. In Flanders, the support of primary caregivers and professional caregivers, along with the further development of home care, is a policy priority. The 'Bejaardendecreet' (Decree on the Elderly) (B.S. 30.VIII.1985) was the first step in this process. Before that time, there were only two choices: to stay home and be helped by family or to go to a nursing home. From then on, other intermediate forms of care such as service flats and day care centers were established. The 'Thuiszorgdecreet' (Home Care Decree) of 1998 (B.S. 5.IX.1998) took this evolution a step further. With this decree, six types of facilities for and associations of people in need of care and primary caregivers were recognized and subsidized: services for family care, day care centres and four associations of people in need of care and primary caregivers. Moreover, new services such as local and regional service centres, centres for short residential stays and sit-in services were developed. Since then, the Flemish government has enlarged the supply of home services on the one hand, and has ameliorated their financial accessibility on the other hand. In 1999, the personal contributions one had to pay for family care services were diminished (30 / 03 / 1999). In the same year, the decree concerning the Flemish care insurance (zorgverzekering) was approved of (B.S. 28.X.1999). Since October 1st, 2001 people in need of serious care can receive benefits for non-medical help or services. These benefits can be used for professional home care services as well as for informal care (provided the informal caregiver is registered).

In the French speaking part of the country, home care is regulated mostly by the Decree 'Picque' of June 1989 (B.S. 4.VIII.1989). This decree regulated the

establishment and functioning of 'centres for coordination of care and services at home' (centres de coordination de soins et services a domicile). The goal was to coordinate three groups of services: (1) social services, home nursing services and home-help services; (2) services such as meals on wheels and paramedic services; and (3) general practitioners. In 1998, there were 53 recognized and subsidized coordination centres. Their functioning and the way they are subsidized was further specified in a Decree of March 4th, 1999 (B.S. 18.VI.1999). In this region, the number of home care services is lower. Policy makers hope that the new 'service cheques', which allow to buy service work cheaply, will support informal carers and elderly people willing to stay at home. Also, in the French speaking part of the country, there are more small-scale living arrangements for elderly people (les Cantous).

In Brussels, policy concerning home care is even more complicated. In this Region, federal as well as Flemish and Walloon legislation is applicable (De Lepeleire & Paquay, 2002).

There is no irregular or illegal care market, since there are quite a few public and private provisions. There are different kinds of home-help, services for professional personal care at home, meals services, community care centres, day care, support groups for family carers, transportation services, and shopping services. In some regions however, there is a problem with waiting lists. Supply can not always follow demand.

Some of the initiatives mentioned above work partly (and a few even purely) with volunteers.

There is data on physical and mental problems of people older than 65 years and on the dependency rates, but there seems to be no data on the related need for care.

The future affordability of the social-security system is of great concern to the Belgian government. It is expected that the number of pensioners will increase with about 800,000 between 2010 and 2030. Between 2000 and 2030 the number of pensioners will increase with 40 %. This not only implies a high rise in the costs of pensions, but also an expected increase of health costs of 3.5 % per year from 2003 on. In total, 4700 billion euro would be spent extra between 2005 and 2030 because of the rise in the number of elderly people. To be prepared for this, the federal government installed the 'Silver Fund', a budget that is set up from 2002 on, to be prepared for the year 2030 (http://www.begroting.be/n/h7/h7a/h7a3/h7a3a.htm).Profile of family carers of older people

1 Profile of family carers for older people

The following data are mainly based on the 10th wave of the Panel Study of Belgian Households. In this Panel Study, a number of questions concerning caring are asked. There is no (recent) study that deals exclusively with in-home care or the profile of family carers.

1.1 Number of carers

According to the Panel Study of Belgian Households, 5.89 % of Belgians older then 16 years of age were caring – without pay – for someone who was ill, handicapped or elderly in 2001 (PSBH, wave 10).

1.2 Age of carers

The average age of the carers is 56 and ¾ years, with a minimum of 20 years and a maximum of 89 years. Table 1 shows the age distribution. Over halve of the family carers are between 46 and 65 years of age.

Table 1: Table 1: Age distribution of people who in 2001 cared without pay for someone who was ill, handicapped or elderly (PSBH, wave 10)

Age class	Percentage of carers
Between 16 and 25 years of age	2.15
Between 26 and 35 years of age	3.07
Between 36 and 45 years of age	15.95
Between 46 and 55 years of age	23.31
Between 56 and 65 years of age	30.06
Between 66 and 75 years of age	18.10
Between 76 and 85 years of age	6.44
Older than 85 years	0.92

1.3 Gender of carers

69.33 % of carers are female and only 30.67 % are male. There is no significant connection between age and sex of the carers.

1.4 Income of carers

There are many missing values for income in the Panel Study database. More than halve of the carers did not answer that question. However, we do see that carers are significantly more often pensioners, housewives / househusbands or unemployed people then non-carers. Table 2 shows the professional activities of the carers in 2000.

Table 2: Professional situation of carers in 2000 (PSBH, wave 10)

Professional situation	Percentage of carers
Paid work (part time or full time)	36.54
Work program or apprentice	0.32
Self-employed or profession	3.85
Unpaid work in family business	0.96
Student or trainee	1.28
Unemployed	6.73
Pensioner	28.21
Housewife or househusband	20.19
Other non-professional activity	1.92

Of those who do have paid work, about 30 % works part-time. When we look at all these data, we can assume that the average income of the family carers is not very high.

1.5 Hours of caring and caring tasks, caring for more than one person

On average, the caregiver spends 17.5 hours per week on caring tasks, with a minimum of 1 hour and a maximum of 99 hours per week. There is no clear data on how many people are being cared for per carer.

1.6 Level of education and / or Profession / Employment of family carer

No data available.

1.7 Generation of carer, Relationship of carer to OP

59 % of the people who are cared for, are a member of the household of the carer. Table 3 shows the relationship between the caregiver and the care receiver.

Table 3: Relationship between caregiver and care receiver (PSBH, wave 10)

Caregiver(s)	Percentage
Husband / partner	14.89
Parent(s)	46.82
In-law(s)	14.33
Child(ren)	12.75
Other family member	16.99
Non-family member	13.31

1.8 Residence patterns

The vast majority of carers is married (see Table 4).

Table 4: Marital state of caregivers (PSBH, wave 10)

Marital status	Percentage
Married	66.36
Divorced	11.84
Widow(er)	9.35
Never married	12.46

1.9 Working and caring

Only 39.26 % of carers work at least 15 hours a week. Of those who do not work at least 15 hours per week, only 4 % has stopped their professional activities temporarily. They took leave (see § 5.7) to have time for caring. 81.12 % of those who do not work at least 15 hours a week, are pensioners (See also § 1.4).

1.10 General employment rates by age

We give detailed information for the Flemish Region in Table 5. For the whole of Belgium, in 2003, 53.37 % of men and 31.92 % of women between 50 and 65 years of age were active on the labour market (N.I.S.).

Table 5: The Flemish population (45+) according to employment and sex (2001) (%)

a. Women	45-49 y	50-54 y	55-59 y	60-64 y
Student or trainee	1	1	2	2
Employed	67	48	23	5
Unemployed	2	1	1	0
Temporarily not working	0	0	0	0
Housewife	21	31	41	30
Disabled	4	6	5	2
Not active for other reasons	3	10	14	3
Retired	1	3	13	59
Total	100	100	100	100
b. Men	**45-49 y**	**50-54 y**	**55-59 y**	**60-64 y**
Student or trainee	0	0	1	1
Employed	90	82	53	17
Unemployed	2	2	2	0
Temporarily not working	0	0	0	0
Housewife	0	0	0	0
Disabled	4	6	9	8
Not active for other reasons	2	5	11	6
Retired	1	5	24	67
Total	100	100	100	100

Source: WAV (www.wav.be)

1.11 Positive and negative aspects of care-giving

In 1998, in a national research 523 elderly people were interviewed (43 % men and 57 % women) about different forms of physical, sexual, psychological and financial abuse (Vandenberck, Opdebeeck & Lammertyn, 1998). The results showed that 2.5 % was confronted with physical abuse after the age of 60 years. More than half of the perpetrators were acquainted to the victim, mostly family members. Psychological violence occurred more often after the age of 60 years then before, and the victims were more often female (30.7 % of women) then male (20.4 % of men). The most common complaints were: 'reproaches' and 'being ignored'. Six out of ten complaints referred to family members. Also, the psychological violence often was of long term (years) and occurred several times a week. Financial violence did also occur more after the age of 60. It usually was about theft and most perpetrators (75 %) were unknown to the victim. Sexual violence did not occur very often, but when it did, the perpetrator in most cases was a family member also. In summary, one out of five elderly people was confronted with some kind of violence after their

sixtieth birthday. Women were more likely to be victims (23.3 % versus 15 %). Most perpetrators are acquainted to the victim (60 %).

In a second research, carer abuse in residential care was investigated (Casman, Lenoir & Bawin Legros, 1998). In 100 rest homes and nursing homes, 3 female inhabitants were interviewed, along with in total 80 persons who worked in the homes in different functions. Physical violence was seldom mentioned, but verbal active aggression (mostly insults) was. This mostly was about rendering infantile, lack of respect or intolerance for criticism.

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

There is no data available on this issue.

1.13 Other relevant data or information

Caregivers help by doing the following tasks (see Table 6):

Table 6: Tasks performed by informal caregivers (PSBH, wave 10)

Task	Yes (percentage)	No (percentage)
Preparing hot meals	42.90	57.10
Doing the laundry	50	50
Personal hygiene	36.22	63.78
Cleaning the house	39.68	60.32
Taking care of medication	47.77	52.23
Helping with eating	20.77	79.23
Listening to stories and complaints	76.25	23.75
Other	54.34	45.66

2 Care policies for family carers and the older person needing care

We will first give an overview of the Belgian Social Security system, since this heavily influences the care and health market (see http://www.socialezekerheid.fgov.be/brochure-index.htm).

The classical social security contains seven sectors:

- old-age and survivor's pensions
- unemployment
- insurance for accidents at work
- insurance for professional disease
- family benefits
- sickness and disability insurance
- annual vacation.

Grossly, the entire classical social security system is divided into a system for salaried persons, one for self-employed persons and one for civil servants.

The social assistance or residual system contains:

- the subsistence minimum
- the income guaranteed for the aged
- the guaranteed family benefit
- the benefits for the disabled.

The system is financed mainly by social contributions. For salaried persons, the contributions come from employers as well as from employees (see Table 7).

Table 7: Employee and employer contributions for the social security system (in %)

Sectors	Employee contribution (%)	Employer contribution (%)	Total (%)
Sickness and invalidity			
medical care	3.55	3.80	7.35
invalidity benefits	1.15	2.35	3.50
Unemployment	0.87	1.46	2.33
Pensions	7.50	8.86	16.36
Family benefits	0.00	7.00	7.00
Accidents at work	0.00	0.30	0.30
Professional disease	0.00	1.10	1.10
Total (= 'global contribution')	**13.07**	**24.87**	**37.94**

Source: http://www.socialezekerheid.fgov.be/brochure-index.htm

Self-employed persons pay quarterly social security contributions to the insurance fund they are associated with. The contribution is calculated on the self-employed person's net professional labour income in the third calendar year preceding the year during which the contributions were paid. The amounts for 2001 (reference year 1998) are in Table 8.

Table 8: Contributions for social security for the self-employed in 2001

Professional income per ceiling	Amount of the contribution
Up to € 10,117.18	€ 422.39
Between € 10,117.18 and € 49,076.97	16.70 % of net professional income
Between € 49,076.97 and € 71,786.89	12.27 % of net professional income
More than € 71,786.89	€ 0

Source: http://www.socialezekerheid.fgov.be/brochure-index.htm

Civil servants employed in the Belgian federal government only have to pay a personal contribution of 7.5 % for survivor's pensions and 3.55 % for the medical care sector. There also is an employer's contribution of 3.80 % for the medical care sector. Civil servants working at the local and provincial administrations pay the following contributions:

Table 9: Contributions for social security for civil servants of local and provincial administrations

Sectors	Employee contribution (%)	Employer contribution (%)	Total (%)
Sickness and invalidity	3.55 %	3.8 %	7.35 %
Pensions	7.5 %	20 %	27.5 %
Family benefits	0 %	5.25 %	5.25 %
Professional disease	0 %	0.17 %	0.17 %
Contribution for wage moderation	0 %	6.19 %	6.19 %
Contribution for child attendance	0 %	0.05 %	0.05 %
Total (= 'global contribution')	**11.05 %**	**35.46 %**	**46.51 %**

Source: http://www.socialezekerheid.fgov.be/brochure-index.htm
Also, a percentage of VAT revenue (about 21 % of total VAT revenue in 2000) is transferred to social security.

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

A 1993 Eurobarometer study shows that elderly people in Belgium think that the family is less willing to care for older relatives. 32.4 % of the respondents strongly agreed with this proposition, 34.0 % agreed, 18.2 % disagreed slightly, 10.4 % disagreed strongly and 4.1 % did not answer the question (Commission of the European Communities, 1993). The evidence however showed that in practice, the family was willing to care. Two-thirds of the care being supplied to older people came from within their families.

There seems to be no change in the willingness of families to care, but there are changes in the availability of family members for giving care. Families are smaller, women participate more in the labour market and the mobility of families has increased. All these evolutions leave less family members nearby to provide care.

There is a trend for the government to promote the willingness to provide family care for persons in need of care. To this end, the government has established a number of financial and other stimuli (see infra). It is a policy goal to keep people at home for as long as possible, preferably until the very end. To that extent, services have been developed and extended, albeit not necessarily enough to cover for the increase in the number of elderly people.

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

There are several federal and local compensation benefits for dependency or diminished independency (see infra § 5.7.1). The definitions of dependency differ between policy measures. The following aspects are usually taken into account:

- the ability to move oneself
- the ability to prepare and to eat food
- the ability to take care of personal hygiene and to dress oneself
- the ability to maintain one's house and to do household work
- the ability to live without supervision, to be conscious of danger and to be able to avoid danger
- the ability to communicate and for social contact.

Also the Katz-scale is widely used.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

There is no legal obligation for families to provide care for older family members. However, families can be forced to help finance residential care for a parent or grandparent who cannot afford this him- or herself. In that case, the local Public Centre for Social Welfare will finance the residential care, but the PCSW can claim (part of) this money back from children (and exceptionally grandchildren) with sufficient income.

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

No.

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)?

In order to draw old age pension, the limit is legally set on 65 years of age. However, many people withdraw from the labour market at a much earlier age. In 2002, only 29.3 % of women and 52.6 % of men (40.9 % of men and women) between 50 and 64 years of age were (still) working. In February 2004 94,027 men and 16,170 (110,737 in total) were on early retirement. Moreover, there were 74,672 older men and 66,546 older women (over 50 years of age) unemployed.

(http://www.steunpuntwav.be/cijfers_trends/Cijfers.htm)

2.2 Currently existing national policies

2.2.1 Family carers

See 2.2.2

2.2.2 Disabled and / or dependent older people in need of care / support?

Pressure groups of family carers have been pleading for a social statute for the informal carer at home. This social statute should mediate some negative consequences of staying at home to care for a family member, especially where social security rights are considered. The government has partly answered this call by organizing the paid leaves in the system of 'interruption of career' mentioned in § 2.2.3, but this is not an end point for the pressure groups.

Since 2004, family carers and people in need of care and support can buy 'service cheques'. This system was installed by federal government with a double goal: to promote neighbourhood services on the one hand, and to conquer unemployment and moonlighting on the other hand. People can pay for household help with service cheques. These can be in-house activities such as cleaning, washing and ironing, small repair works on clothes and cooking and out-house activities such as doing shopping and transportation. With the cheques, people only pay € 6.20 per hour for the help. Moreover, the cost of the cheques is tax deductible for the buyer.

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

There are several possibilities to combine work and care. However, usually, much depends on the willingness of the employer and on the financial possi-

bilities of the employee, since the financial compensations are either low or non-existing.

1 Leave for compelling reasons

Every employee can each year take up 10 days (without pay) for compelling reasons. Possible compelling reasons are: the hospitalization and an illness or an accident of someone who lives under the same roof as the employee (child, spouse, parent). In some sectors, more days were regulated by collective labour agreement.

2 Leave without pay

If the employer approves, people can take a leave without pay for a certain period (a year, a month, several months, …).

3 Time credit and the 'interruption of career' system

Time credit is for employees in the private sector, while the 'interruption of career' system is for public sector employees.

Time credit allows interrupting the career completely or partly. The goal of the interruption does not have to be made explicit, so it can be used for other reasons than caring for an elderly person. Time credit is a right in the private sector, but no more than 5 % of the employees of a company can use it at the same time. In companies with less than 11 employees, the approval of the employer is necessary. A collective labour agreement within a company or with a sector can exclude some categories of employees from the time credit system. There are three modalities of time credit:

- a full suspension of employment, for full time as well as for part time employees, or a diminishment of employment to a part time employment for employees who worked at least 4 / 5ths during the last twelve months;
- a suspension of employment for 1 / 5th (staying at home one day a week);
- for employees who are at least 50 years of age: a diminishment of the employment with 1 / 5th or with 1 / 2nd.

A *full suspension of employment* or working part time if one worked at least 4 / 5ths during the last twelve months can last minimum 3 months and maximum a year. A collective labour agreement in the sector can stipulate that longer suspensions are possible, with a maximum of 5 years. To be entitled to this kind of time credit, one has to have worked for the same employer during at least 12 of the last 15 months. During the period of time credit, the state offers compensations for loss of pay. The amounts are:

Table 10: Benefits for taking up full-time or part-time time credit in the private sector (2004)

Full suspension		Part-time suspension	
> 5 years of seniority	< 5 years of seniority	> 5 years of seniority	< 5 years of seniority
€ 394,59	€ 526,12	€ 197,29	€ 263,06

Suspension of employment with 1 / 5th allows you to stay home one day a week or two halve days a week. To be entitled, you have to work full time in a week system. You also have to have worked for the employer for at least 5 years, of which the last 12 months have to be full time. You can take this kind of time credit up for a minimum of 6 months and a maximum of 5 years. During the period of time credit, the state offers compensations for loss of pay. The amounts per month are:

Table 11: Benefits for taking up time-credit one day a week in the private sector (2004)

For a person living alone*	Others
€ 167,66	€ 129,92

* Living alone or with one or more children of whom at least one is supported by you.

Suspension of employment with 1 / 5th or 1 / 2nd for employees older than 50 years of age is limited to people who worked for at least 20 years, of which at least 5 years with the current employer and for at least 4 / 5ths during the last twelve months. They can diminish employment with 1 / 5th for minimum 6 months, and maximum the duration of their employment until their pension or they can reduce their employment to half time for at least 3 months and maximum until they retire. During the period of time credit, the state offers compensations for loss of pay. The amounts per month are:

Table 12: Benefits for taking up time credit for employees in the private sector who are older than 50 years (2004)

Reduction to halve time employment	Reduction of employment with 1 / 5th	
	For a person living alone*	Others
€ 392,98	€ 182,54	€ 220,28

* Living alone or with one or more children of whom at least one is supported by you.

In principle, the **'interruption of career' system** is not a right, except for employees of federal government with a contract and who worked for the same employer for the last twelve months. Also, employees of local and provincial governments have a right to full interruption of career or reduction of employment with 1 / 5th or to halve time, with an exception for certain categories of employees.

In this system, there are also three modalities:

- Full suspension of career
- Partial suspension of career for employees younger than 50 years of age
- Partial suspension of career for employees older than 50 years of age.

Full suspension of career can be taken up for minimum 3 months and maximum 12 months. The total duration during the whole career can in principle not exceed 72 months. During the period of suspension of career, the state offers compensations for loss of pay. The amounts per month are:

Table 13: Benefits for full suspension of career for government employees

Normal compensations	Increased compensations if two children	Increased compensation if three children or more
€ 330,25	€ 361,67	€ 393,12

Source: RVA, amounts for 01 / 06 / 2003,
(www.rva.fgov.be/D_opdracht_LBO/Regl/Werknemers/Algemeen/Ar_020191/)

Partial suspension of career for employees younger than 50 years of age is possible for 1 / 5th, 1 / 4th, 1 / 3rd or ½. It can be taken up for periods of minimum 3 months and maximum of 72 months, with a total of maximum 72 months. During the period of suspension of career, the state offers compensations for loss of pay. The amounts per month are:

Table 14: Benefits for partial suspension of career for government employees

	Normal compensations	Increased compensations if two children*	Increased compensation if three children or more*
Reduction with 1 / 5th	€ 66.04	€ 72.34	€ 78.61
Reduction with 1 / 4th	€ 82.57	€ 90.42	€ 98.28
Reduction with 1 / 3rd	€ 110.07	€ 120.56	€ 131.05
Reduction with 1 / 2	€ 165.12	€ 180.85	€ 196.54

* youngest is younger than 3 years or is adopted less than 3 years ago
Source: RVA, amounts for 01 / 06 / 2003
(www.rva.fgov.be/D_opdracht_LBO/Regl/Werknemers/Algemeen/Ar_020191/)

Partial suspension of career for employees older than 50 years of age is also possible for 1 / 5th, 1 / 4th, 1 / 3rd or ½. It can be taken up for periods of minimum 3 months and maximum until the employee retires. During the period of suspension of career, the state offers compensations for loss of pay. The amounts per month are double those for employees younger than 50 years of age.

Table 15: Benefits for partial suspension of career for government employees older than 50 years

	Normal compensations	Increased compensations if two children*	Increased compensation if three children or more*
Reduction with 1 / 5th	€ 132.10	€ 138.40	€ 144.67
Reduction with 1 / 4th	€ 165.12	€ 172.99	€ 180.85
Reduction with 1 / 3rd	€ 220.13	€ 230.65	€ 241.12
Reduction with 1 / 2	€ 330.25	€ 345.95	€ 361.67

* youngest is younger than 3 years or is adopted less than 3 years ago
Source: RVA, amounts for 01 / 06 / 2003
(www.rva.fgov.be/D_opdracht_LBO/Regl/Werknemers/Algemeen/Ar_020191/)

4 Interruption of career for giving medical assistance

Employees of all sectors can interrupt their career for giving medical assistance to a family member (to second degree) that is seriously ill. A serious illness is an illness or a medical intervention that is considered as such by a medical doctor and for which the medical doctor thinks that any form of social, familial or mental / moral assistance is necessary for recovery.

This kind of interruption can be full time for 12 months or part time (1 / 2 or 1 / 5th) for 24 months for one patient. In other words, the right renews for another patient.

Normally, this specific form of interruption of career can not be refused. However, if the employer is private sector and has less than 10 employees, the interruption with 1 / 2nd or 1 / 5th is not a right, but needs approval from the employer. Also, a private sector employer with 50 employees or less can refuse this right for organizational reasons, if the employee already interrupted his or her career for 6 months full-time or for 12 months part-time for giving medical assistance.

During the period of suspension of career, the state offers compensations for loss of pay. For somebody who suspends employment full time, the amounts per month are € 547.37 for a full time employee and this amount times the number of hours normally worked divided by the number of hours in a full-time employment for a part-time employee. For a part-time suspension of employment, the amounts are:

Table 16: Compensations for interruption of career for giving medical assistance

Suspension of career with 1 / 2nd		Suspension of career with 1 / 5th	
Employee < 50 years	Employee > 50 years	Employee < 50 years	Employee > 50 years
€ 273.68	€ 547.37	€ 109.47	€ 218.95

Source: R.V.A., amounts for 01 / 06 / 2003

5 Interruption of career for palliative leave

An employee can take a leave for giving palliative care. Any form of assistance (medical, social, administrative and psychological) and caring for a person with an incurable disease in the terminal phase, is considered palliative care.

This kind of leave is a right for employees (with a few exceptions) in any sector. People can either take full time leave for 1 month (can be prolonged by another month) or reduce the number of hours they work during 1 month (also can be prolonged by another month). Taking leave for longer than 2 months for one patient is not possible. During the period of suspension of career, the state offers compensations for loss of pay. The amounts are the same as for an interruption of career for giving medical assistance (see supra).

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

Under certain circumstances, the Flemish Community government gives an incentive bonus on top of the compensations offered by federal government for taking up time credit. If an employee of the private sector takes up (1) time credit for

- assistance of or care for a parent older than 70 years if age;
- caring for a seriously ill family member or for somebody (also a non-relative) who is terminally ill;
- caring for children born or adopted after January 1st, 1998 or for a child with a handicap of at least 66 % born after January 1st, 1994;

or (2) takes up an interruption of career for giving medical assistance, for giving medical care or for taking care of young children,

then the Flemish Community government gives an additional compensation called ‘care credit’. These compensations are granted on top of the federal compensations.

In the course of a career, a person can receive this care credit for a maximum duration of 1 year. Three months are added per child born or adopted after January 1st; 1998 (or January 1st, 1994 if the child has a handicap of at least 66 %). The monthly credit amounts to:

Table 17: Monthly incentive bonus from the Flemish Community government for taking up time credit in certain circumstances

Situation before the leave	Situation during the leave	Normal Flemish time credit	Flemish time credit for people who live alone or with children of whom they support at least one
works at least 75 % of a full time job	takes full time leave	€ 156.06	€ 194.55
	takes half time leave	€ 104.04	€ 142.53
	takes 1 / 5th leave	€ 52.02	€ 90.51
works at least 50 % of a full time job	takes full time leave	€ 104.04	€ 142.53
works less than 50 % of a full time job	takes full time leave	€ 52.02	€ 90.51

Source: Vlaamse Administratie Werkgelegenheid, amounts for 01 / 06 / 2003

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

There are quite substantive differences between the regions in Belgium (see § 2.3). The long-term care insurance does not exist in the Walloon Region. Moreover, provinces and / or municipalities can provide additional financial or other support for carers (see § 5.7.1).

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)			X[1]		X			
Counselling and Advice (e.g. in filling in forms for help)			X[2]	X[3]	X			
Self-help support groups		X				X	X[4]	
"Granny-sitting"		X			X	X	X	X
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X				X[5]		
Weekend breaks			X[6]		X	X		X
Respite care services			X[7]		X	X		X
Monetary transfers	X							
Management of crises			X[8]	X				
Integrated planning of care for elderly and families (in hospital or at home)	X							
Special services for family carers of different ethnic groups	X							
Other								

1 The GDTs (see Appendix) can help carers to draw up a care plan. The SITs in Flanders and Brussels do the same (see Appendix).
2 Also provided by GDTs (federal) and SITs (only in Flanders and Brussels).
3 Every local Public Centre for Social Welfare is obliged to organize a service that helps people to apply for whatever they are entitled to and that also helps them to fill out forms.
4 However, some groups may receive subsidies from the government (e.g. the Working Group Home Carers (Werkgroep Thuisverzorgers) and the Centre Home Care (Steunpunt Thuiszorg) do).
5 This kind of training is provided by the 'Working Group Home Carers'. This is an independent and pluralistic pressure group of home carers. It is recognized by the government and receives subsidies. There is one central office and there are regional contact persons. The organization however only works in Flanders and Brussels (Dutch speaking). Specific training is also offered by the Expertise Centres for Dementia in Flanders (see Appendix) and by the Alzheimer Association all over Belgium.
6 Weekend break and respite care services are provided by nursing homes.
7 Weekend break and respite care services are provided by nursing homes.
8 The emergency services at general hospitals are obliged to offer help in crisis situations.

3.1 Examples

3.1.1 Good practices

Integrated Services for Home Care (GDTs)

Cooperation Initiatives in Home Care (SITs)

3.1.2 Innovative practices

Expertise Centres for Dementia

Small-scale normalized living for people suffering from dementia

4 Supporting family carers through health and social services for older people

Table 18 shows the percentage of the population receiving long-term formal care at home in 2001, by age group. As people get older, they use more formal care at home.

Table 18: Percentage of population receiving long-term formal care at home, by age group in 2001

Age group	Percentage
0-59	0.14
60-74	1.68
75-79	6.07
80-84	13.09
85-89	18.49
90-94	25.68
95+	29.51
Total	1.20

Source: Belgian Institute for Health Insurance, calculations by Federal Planning Bureau (Mestdagh & Lambrecht, 2003)

4.1 Health and Social Care Services

4.1.1 Health services

Health services are widely available. In the year 2000, there were 7.1 hospital beds, and 4.2 doctors (general practitioners, specialists and candidate-specialists) per 1000 inhabitants (Eurostat). In both aspects, Belgium ranked fourth in the European Community. A 2001 survey shows that 59 out of a 100 households thinks that the supply of health services (doctor, pharmacist, hospital, …) is 'normal' in their neighbourhood. 33 % is very satisfied with the supply and 8 % thinks the supply is insufficient. Satisfaction is largest in the Brussels Region and smallest in the Walloon region. Dissatisfaction is largest in the Walloon Region and smallest in the Flemish region (NIS, 2001, www.statbel.fgov.be/census).

Table 19: The number of health care providers on 31 / 12 / 2002

Health care provider	Number
Medical doctor	
general practitioners	21.698
specialists	19.065
Pharmacists	11.191
Dentists	8.553
Nurses	58.306
Physiotherapists	27.475
Speech therapists	3.633
Orthopeadists	559
Bandagers	8.357
Bandagers (implants)	804
Opticians	3.333
Audicians	952

Source: NIS, RIZIV

Life expectancy is lower and morbidity is higher among people from lower social strata (Gadeyne & Deboosere, 2002; Deleeck, 2002). For example, men of 25 years of age have an average life expectancy of 49.6 years, of which they experience on average 37.5 years as 'in good health'. For a 25 year old man with only primary schooling, the life expectancy in good health is only 28.1 years, while for a 25 year old man with a university degree, this is 45.9 years. The differences are even bigger for women. Also, people with a lower social status also have more chronic illnesses, suffer more from long-term disabilities, they experience their health status as less favourable, and they have poorer mental health than people with a higher social status (Bossuyt & Van Oyen, 2000).

Ironically, however, people from lower social strata make less use of health care. Although sufficient health care services are available, the cost (the personal contribution) is too high for people with limited means.

4.1.1.1 Primary health care

As stated above, the primary health care sector is widely developed. The personal cost can however be a barrier to access these services. If one needs a lot of medical care, the personal contributions to be paid (the part not paid by health insurance) can be quite a burden. Also, home care still proves to be more expensive than hospital care (for which one can for example have private insurance). Figures for the Flemish Community show that a Flemish household on average spends 7 % of its available income on medical care. These expenses rise from 2 % for a young household to 13 % for a household where the reference person is at least 75 years of age. The expenses for medical care go to care providers for 59 %, to medication for 28 %, to institu-

tions for 11 % and to medical appliances for 2 %. About one quarter of the households indicates that the expenses for medical care are difficult to handle. In a household where the reference person is a woman, this even amounts to 40 % and in households where the reference person has very low education to 49 %. 6 % of the households indicate that certain medical care is postponed because of financial impediments (VRIND, 2002, http://aps.vlaanderen.be/statistiek/publicaties/stat_Publicaties_vrind2002.htm). The 2001 national Household Budget Research (NIS, 2004) showed that the expenses for medical care in health care in an average Belgian family were € 1,336, which is 11.1 % more than the previous year. There were regional differences: expenses rose with 8.4 % in the Walloon region, with 9.7 % in the Flemish region and with 23.3 % in the Brussels region. A Brussels' family on average spends € 1,615 on medical care.

In the past, the federal government tried to counter this problem with the *'preferential compensations'* in the Law on Medical Care and Benefits. This law provided additional benefits from medical security for widows, widowers, persons with a handicap, pensioners and orphans on condition the family income was under a certain limit. This right to additional benefits was extended in 1997 to people living on the minimex-income, people having a right to the guaranteed income for the elderly or to compensations for persons with a handicap, and children with a handicap. Later on, the same right was given to some categories of the unemployed of a higher age. Also, the Program Law of August 6th, 1993 and a Royal Resolution of November 3rd, 1993 installed the *'social franchise'*. The social franchise reimburses all medical costs for 100 % for categories of people living on benefits who pay more personal contributions per year than a certain amount.

These measures however proved to be insufficient. Therefore, the federal government has established the *'maximum invoice'* (Law of June 6th, 2002). Much alike the social franchise, the maximum invoice reimburses all medical costs if the personal contributions of a citizen exceed a certain limit. There are three types of maximum invoice:

- the social maximum invoice, based on the social category of the claimant;
- the maximum invoice for limited incomes, based on the family income of the claimant and executed by the social security administration;
- the fiscal maximum invoice, based on the family income and executed by the fiscal administration.

To be entitled to the **social maximum invoice**, a family must have paid at least € 450 personal contributions during a calendar year, and the family must have at least one member that belongs to the following claimants:

- widows and widowers, persons with a handicap, pensioners and orphans;
- people entitled to the minimex-income;

- people entitled to the guaranteed income for the elderly
- people older than 50 years of age and fully unemployed since at least one year
- people with a handicap (and recognized as such)

If the family income is lower than € 13,956.17 and the family paid at least € 450 in personal contributions during the calendar year, the family is entitled to the **maximum invoice for limited incomes.** This is also the case for families with a net income between € 13,956.17 and € 21,455.00, who paid at least € 650 in personal contributions. Also, children under 16 years of age who paid at least € 650 in personal contributions can obtain the maximum invoice individually. Moreover, exceptions ('cases worthy of consideration') can be given for example if the family income suddenly diminished considerably because a family member did not work during the past 6 months.

All families can obtain the **fiscal maximum invoice**, if the amount of personal contributions the family paid is higher than the reference amount that matches with its annual income (see Table 20).

Table 20: Family incomes and reference amounts for the fiscal maximum invoice

Income	Minimum amount of personal contributions
€ 21,455.01 < income < = € 28,953.84	€ 1,000
€ 28.953.85 < income < = € 36,140.23	€ 1,400
€ 36,140.24 < income < = € 51,658.65	€ 1,800
Income > € 51,658.66	€ 2,500

Source: RIZIV

These policy measures are all the more important for elderly people, since research shows they use primary health care more often than younger people, with the exception of dental care (see Table 21).

Table 21: Average number of yearly consultations with general practitioners, specialists and dentist, according to age-group, for the Flemish region in 2001

	0-14 y	15-24 y	25-34 y	35-44 y	45-54 y	55-64 y	65-74 y	75+
G.P.	4.1	6.1	5.0	5.1	5.9	9.6	11.4	13.5
Specialist	1.6	3.1	2.3	2.6	2.85	2.9	4.7	2.8
Dentist	2.2	2.4	1.4	2.6	2.5	2.0	1.7	1.0

Source: Gezondheidsenquête, Wetenschappelijk Instituut voor Volksgezondheid

General practitioners generally make quite a lot of house calls. Specialists and dentist however do not. In the year 2000 GPs made 20,847,798 house calls (Vandaele, http://www.vhp.be/vhp/ftpdown.htm).

4.1.1.2 Acute hospital and Tertiary care

See 4.1.1.3

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

Geriatric wards in general hospitals had a capacity of 6,592 beds in 1996. During that year, these wards provided 2,035,443 lay days. Their occupancy rate was 84.6 %.

Elderly people often enter the geriatric ward in a crisis situation, e.g. after a fall or because of a breakdown of the main carer. The duration of the stay in the geriatric ward is limited. The number of beds for long-term hospital care was decreased over the years. Due to a rationalization of the health policies, older people needing long-term care are being transferred from hospital to nursing homes. Yet, giving the ageing foreseeable in the future, more elderly people will need hospitalization and this could lead to a gap between the number of hospital beds needed and the number of hospital beds available. In general, the number of hospital beds per 1,000 inhabitants increased from 8.3 to 9.4 between 1970 and 1980. Since then the density of hospital beds decreased. By 1997, it had dropped to 7.3 beds per 1,000 inhabitants. We only have figures until 1994 for the number of hospital beds specifically for long-term care. These show that in 1990, there were 8.27 hospital beds for long-term care per 1,000 people age 65 or older. By 1994, this had dropped to 7.32 per 1,000 people of that age group. (Mestdagh & Lambrecht, 2003). We can assume that since then, the number has dropped even more.

Also, the number of geriatricians is relatively low, considering the (growing) number of elderly people. In July 2001, there were 262 geriatricians in Belgium, on a total of 18,553 specialists. 50 of those geriatricians at that time were older than 65 years themselves. Of those 262, 174 (142 under 65 years of age) are Flemish and only 88 (70 under 65 years of age) were Walloon (Ministry of Public Health). Bearing in mind that the number of paediatricians in 1998 was 1,220, these are low figures (Ministry of Public Health, http://www.health.fgov.be/AGP/nl/manpower/gegevens/algemene-gegevens/stat_prat_med.htm).

4.1.1.4 Are there hospice / palliative / terminal care facilities?

Palliative care is provided at home as well as in (specialized wards of) hospitals. A palliative support care team assists at home. The team is multidisciplinary and consists of a general practitioner, a nurse and possibly a psychologist, paramedics and volunteers. They do not replace, but offer assistance to the home care team that already exists. This kind of help is free for the patient and his or her family.

Palliative care is also provided in most nursing homes and hospitals. Some hospitals and some nursing homes have a specialized ward for this kind of care.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

The degree to which family carers are expected to play an active role in nursing home care differs between nursing homes. In small-scale normalized living projects for people suffering from dementia (see Appendix), family members play an important role in the caring process. They are still an important part of the resident's life and are treated as such. In most nursing homes, family carers can play an active role (laundry et cetera), but are not obliged to do so. All these services are also provided by the nursing home.

4.1.2 Social services

4.1.2.1 Residential care (long-term, respite)

Since not everybody has a family that can help and since in some situations, family care does not suffice anymore, residential care still is an essential part of the caring process for elderly people. In the year 2000, there were 1,875 rest homes (ROB, (at least in principle) for people with limited disabilities) and 896 nursing homes (RVT, for people with major disabilities) in Belgium. Those rest homes and nursing homes took care of respectively 84,193 and 28,670 people in 1999. ROB-beds in principle are for people with no or very limited disabilities, but the demand is of this kind that many ROB-beds are taken up by elderly inhabitants who do have serious disabilities. Many rest homes and nursing homes have waiting lists, especially those nursing homes that have special wards for people suffering from dementia.

Respite care is provided within nursing homes. This is organized regionally. In the Flemish Region, there are 122 centres for respite care. In the Walloon Region, there are almost no facilities for respite care.

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes)

Table 22 shows the age distribution and degree of dependency of people residing in the rest homes and the nursing homes in 2001.

Table 22: The age distribution and degree of dependency of inhabitants of rest homes and nursing homes (2001)

RVT	0-59		60-74		75-79		80-84		85-89		90-94		95+		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
B	171	0.00	858	0.06	1,102	0.29	1,426	0.75	2,001	1.59	1,478	3.09	476	4.33	7,512	0.07
C	554	0.01	2,826	0.19	3,839	1.01	5,392	2.83	7,994	6.35	6,682	13.97	2,816	25.61	30,103	0.29
Total	725	0.01	3,684	0.25	4,941	1.29	6,818	3.58	9,995	7.94	8,160	17.07	3,292	29.94	37,615	0.37
ROB	**0-59**		**60-74**		**75-79**		**80-84**		**85-89**		**90-94**		**95+**		**Total**	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
O	705	0.01	3,967	0.27	4,062	1.06	5,426	2.85	7,014	5.57	4,677	9.78	1,603	14.58	27,454	0.27
A	407	0.01	2,313	0.16	2,482	0.65	3,479	1.82	4,849	3.85	3,491	7.30	1,046	9.51	18,067	0.18
B	477	0.01	2,045	0.14	2,464	0.65	3,565	1.87	4,818	3.83	3,580	7.49	1,181	10.74	18,130	0.18
C	334	0.00	1,718	0.12	2,305	0.60	3,247	1.70	4,866	3.87	3,845	8.04	1,673	15.22	17,998	0.18
Total	1,923	0.02	10,043	0.67	11,313	2.96	15,717	8.24	21,547	17.12	15,593	32.91	5,503	50.05	81,639	0.80

RVT+ ROB	0-59		60-74		75-79		80-84		85-89		90-94		95+		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
O	705	0.01	3,967	0.27	4,062	1.06	5,426	2.85	7,014	5.57	4,677	9.78	1,603	14.58	27,454	0.27
A	407	0.01	2,313	0.16	2,482	0.65	3,479	1.82	4,849	3.85	3,491	7.30	1,046	9.51	18,067	0.18
B	648	0.01	2,903	0.19	3,566	0.93	4,991	2.62	6,819	5.42	5,058	10.58	1,657	15.07	25,642	0.25
C	888	0.01	4,544	0.30	6,144	1.61	8,639	4.53	12,860	10.22	10,527	22.02	4,489	40.83	48,091	0.47
Total	2,648	0.03	13,727	0.92	16,254	4.26	22,535	11.82	31,542	25.06	23,753	49.68	8,795	79.99	119,254	1.16

Source: Belgian Institute for Health Insurance and Federal Planning Bureau calculations (Mestdagh & Lambrecht, 2003)

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

A rest home (ROB) is defined as one or more buildings that functionally generate a collective residence in which elderly people live on a long-term basis. In the rest home, the usual family and household care is given completely or partly. The legislator further defines elderly people as people of 60 years and older. The residence of people younger than that age must be approved in writing by the care team.

A nursing home (RVT-bed) is for people with long-term care needs, who are heavily dependent on the help of others for the activities of daily living. There are three conditions, assessed with multi-disciplinary evaluation reports and standardized evaluation scales. The three conditions are:

- The person has already undergone all necessary treatment, but this has not completely restored the functions for daily living. However, daily medical supervision or a specialized medical treatment is unnecessary.
- All possibilities for in-home care have been examined, but admission to a nursing home is necessary.
- The person's general health condition demands that, apart from medical care by a general practitioner, a nurse and paramedical care, help with activities of daily living is also necessary.

Rest homes and nursing homes can apply further criteria for admission. Some for example do not admit people suffering from dementia, others exclusively admit people with a diagnosis of dementia.

Income is not a criterion. However, residential care for elderly people is expensive in Belgium. In 1999, the average monthly personal cost for a stay in a single room was € 991.57. Not all costs are necessarily included in this price. Considering that 50 % of the elderly in 1999 received a pension between € 19.73 and € 867.63 per month, we have to conclude that they need savings, the proceeds of the sale of property, or help from relatives to finance their stay. People who need residential care, but cannot afford this, get benefits from the local Public Centre for Social Work (PCSW). The PCSW can then decide to ask for (partial) reimbursement of the children of the person involved. Some PCSW's do so systematically, others never do (Hermans & Lammertyn, 2002).

4.1.2.1.3 Public / private / NGO status

Rest homes and nursing homes can be public, private non-profit or private for-profit. In the Flemish Community, there are 769 nursing homes / rest homes. The majority is private not for profit. Also, for-profit nursing and rest homes on average are smaller (see Table 23). In the French speaking Community, there are 827 nursing homes and rest homes (maisons de repos) with 45,178 beds (http://statistiques.wallonie.be/dyn/14/artcle1.ihtml?ID_SITE=14&ID_CATEGORIE=296&ID_ARTICLE=280&NOM_CATEGORIE=0BAAG&CAT=1&MODE=MAIN). In the Brussels Region, there are 162 bi-communal rest homes and nursing homes, 71 French speaking rest homes and nursing homes, and 1 Flemish rest home (CDCS / CMDC, 2000).

Table 23: The number of rest homes and nursing homes and the number of rest home and nursing home beds in Flanders in 2000

	Number of rest and nursing homes		Number of beds	
	#	%	#	%
Public	239	31.1	22,980	38.9
Private non-profit	330	42.9	27,455	46.5
Private for-profit	200	26.0	8,583	14.5
Total	769	100.0	59,018	100.0

Source: Ministry of the Flemish Community (http://www.ufsia.ac.be/csb/tabel%2010k.pdf)

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

Carers can be involved, but they are not necessarily. Much depends on the carers themselves, and on the policy of the rest house or nursing home in question.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

4.1.2.2.1 Home-help

There are different kinds of home-help and they are not exclusively for older people, although this age group is the main consumer of these services. There is 'help with cleaning' as well as more extensive 'family help' in the house (including cooking, ironing, et cetera). 4.9 % of people between 65 and 74 years of age and no less than 26.1 % of people 75 years and older used family help in 2001 (Demarest et al., 2002). The services for cleaning help provided a total of 8,350,306 hours of help in the Flemish Region and 60,743 hours of help in the Brussels Region in 2001. Family help offered 13,766,377 hours in the Flemish Region and 123,541 hours in the Brussels Region in 2001. Both kinds of services are offered by different non-profit organizations, some of which are public and some of which are private.

Services for help with cleaning normally give priority to people with increased dependency and to people with a lower income. The cost for the person depends on the family income and usually is between € 2.47 and € 7.43 per hour.

Family help services give different kinds of help. Their professionals help preparing meals, clean, do shopping, wash and iron, help with personal hygiene, create a pleasant atmosphere in the home and help with administration. The help is always intended to support home care and to stimulate self-aid. The services are organized by different organizations that have to fulfil the requirements of the Flemish Community to be recognized and subsidized. The cost for the person depends on the family income. Since January 1st, 2002 the personal contribution is minimum € 0.50 per hour and maximum the real cost of the help, which can amount up to € 22.50 per hour. The average personal contribution is around € 3 per hour. The cost can be 30 % higher if help is needed on Saturdays or on weekdays between 8 pm and 7 am and 60 % higher if help is provided on Sundays and public holidays. People who are severely dependent are entitled to a number of discounts:

- a score of at least 35 on the bel-dependency scale entitles to a discount of € 0.35 per hour
- if one needs long-term help (at least a year), a supplementary discount of € 0.25 per hour is granted
- if one needs more than 60 hours of help per month, one is entitled to another supplementary discount of € 0.35 per hour.

In some regions, the services for home-help have waiting lists. The demand is larger than the supply. The budget for this kind of services did not follow the grow in demand of the last years. While the number of people needing care at

home rose with 18 % since 1999, the number of subsidized hours only rose with 8 %. According to its own programmed norms, the Flemish government should have subsidized 15.4 million hours in 2003, but in reality it only subsidized 13.9 million hours.

4.1.2.2.2 Personal care

Professional personal care at home can be given by a nurse (private for profit, private non-profit or public) or by the family help services mentioned in § 4.1.2.1.1. If the nurse or the organization the nurse works for are registered with the National Sickness and Invalidity Insurance Institute (RIZIV), (part of) the costs are reimbursed. For people who are not heavily dependent, the hygienic care is reimbursed per performance, if the application for reimbursement is approved by a medical advisor. For people who are severely dependent, the nurse (or her organization) receives a daily fixed sum according to the degree of the dependency of the person. The nurse is then obliged to give personal hygienic care at least once a day.

There are about 11,000 nurses in Belgium who work as self-employed nurses in home nursing care. About 30 % of them however does not work full-time on a self-employed basis, but also has a full- or part-time job as a nurse in a hospital, nursing home or other service (source: Wit-Gele Kruis).

4.1.2.2.3 Meals service

Meals services are provided by different services, public as well as private. Most Public Centres for Social Welfare have such a service.

People younger than 75 make (almost) no use of meal services, as can be seen in table 24. Also, except in the oldest age group older women make more (or to the same extent) use of home delivered meals than older men do (Mestdagh & Lambrecht, 2003).

Table 24: Percentage of population making use of home-delivered meals, by age group and gender (2001)

Age	Men	Women
35-44	0.1	0.2
45-54	0.3	
55-64	0.8	0.5
65-74	1.9	2.4
75-79	5.3	5.0
80-84	6.8	15.6
85+	23.9	14.6

Source: Health Interview Survey, 2001 (Mestdagh & Lambrecht, 2003)

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

In many municipalities (but not in all) there are local initiatives for transportation for people with diminished mobility and initiatives for shopping services. These can be purely voluntary, but some are organized by the local government or by other non-profit organizations.

4.1.2.2.5 Community care centres

In the Flemish Community, there are about 130 'local service centres'. These are meeting places for people older than 55 and for everybody in need of home care. The goal is to prevent people from getting isolated and to make professional care more accessible. Every local service centre also is an information centre. The Flemish government wants to increase the number of centres to about 400.

There is no such a thing in the Walloon Region. However, the coordination of different home-care services is pretty elaborated. In the French speaking part of the country, home care is regulated mostly by the Decree 'Picque' of June 1989 (B.S. 4.VIII.1989). This decree regulated the establishment and functioning of 'centres for coordination of care and services at home' (centres de coördination de soins et services à domicile). The goal was to coordinate three groups of services: (1) social services, home nursing services and home-help services; (2) services such as meals on wheels and paramedic services; and (3) general practitioners. In 1998, there were 53 recognized and subsidized coordination centres. Their functioning and the way they are subsidized was further specified in a Decree of March 4th, 1999 (B.S. 18.VI.1999).

4.1.2.2.6 Day care ("protective" care)

0.3 % of people between 65 and 74 years of age and 0.7 % of people of 75 years and older used day care in 2001 (Demarest et al., 2002).

There are 79 day care centres in the Flemish speaking part of Belgium and 34 in the French (and German) speaking part.

4.1.2.2.7 Other social care services

Family carers can receive counselling and / or training from recognized support groups such as 'Werkgroep Thuisverzorgers' or 'Steunpunt Thuiszorg'.

In Flanders, there are also sit-in services (Resolution of the Flemish Government of December 18th, 1998). They provide help and assistance that consists of offering company and support when a caregiver is temporarily absent. The maximum number of recognized and subsidized services is determined as one per 100,000 inhabitants per province and for Brussels. These services provide at least 10,000 hours of sit-in care per year, of which at least half is provided by volunteers. Such a service must be reachable at least 32 hours a week, with a good spread over the working days.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modeling of both home and other support care services

4.2.1 Who manages and supervises home care services?

Each service has its own management. However, if a service wants to be subsidized by government (which most services are), it has to comply with the norms and quality standards the government has set.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls?

There are regulated inspections of rest homes, nursing homes and formal in-home services. This control is regulated by law (18 DECEMBER 2003. - Besluit van de Waalse Regering betreffende de bijzondere erkenning van de rust- en verzorgingstehuizen, dagverzorgingscentra voor bejaarden, psychiatrische verzorgingstehuizen en geïntegreerde diensten voor thuisverzorging, B.S. 11.III.2004; 4 APRIL 2003. - Besluit van de Vlaamse regering tot wijziging van het besluit van de Vlaamse regering van 17 juli 1985 tot vaststelling van de normen waaraan een serviceflatgebouw, een woningcomplex met dienstverlening of een rusthuis moet voldoen om voor erkenning in aanmerking te komen, B.S. 21.V.2003)

Flanders has a ‘quality decree for health and social services’ since 2003 (Decree of October 17th, 2003, B.S. 10.XI.2003). The decree applies to every organization that is recognized by the Flemish Community and that is active in the domains of providing care, health education, preventive health care, family care, social welfare, the welcome and integration of immigrants, care for people with a handicap, elderly care, youth care and social care for the reintegration of prisoners. It forces all of these services to have a mission and to monitor the quality of its own activities. If not, the service can lose its recognition and / or be forced to pay a fine.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

There are personnel norms for residential care. Per 30 inhabitants, a nursing home has to have at least 5 full-time certified nurses, among whom one head nurse and at least 5 full-time care workers who received at least a minimum training. A rest home has to have at least 2.5 full time staff with training per 15 inhabitants, among whom at least one certified nurse.

A certified nurse is trained for at least three years. Care workers can have different sorts of training, either received in secondary school (between 12 and 18 years of age) or by taking a course at a later age. This course takes about a year on average and is organized by home care services.

4.2.4 Is training compulsory?

Yes.

4.2.5 Are there problems in the recruitment and retention of care workers?

Many nursing homes and rest homes experience difficulties in finding sufficient certified nurses. The government is trying to amend this by stimulating young people to study to be a nurse and by ameliorating the working conditions and wages of nurses in nursing homes and rest homes.

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels)

4.3.1 Are family carers’ opinions actively sought by health and social care professionals usually?

Communication is often a problem, especially in hospitals. Families are not or only partially informed. It is an issue that needs to be actively worked on. The evolution is positive, but the end is not yet reached. The GDT’s and SIT’s are certainly a step in the right direction, and we also see that communication has become a topic in the training and education of health and social care professions.

5 The Cost – Benefits of Caring

5.1 What percentage of public spending is given to pensions, social welfare and health?

In 2000, 9 % of the Brute Domestic Product was spent on Pensions and 6.2 % was spent on health care. In 2002 these percentages had risen to 9.2 % and 6.6 % (Studiecommissie voor de vergrijzing - Hoge Raad van Financiën, 2003).

5.2 How much - private and public - is spent on long term care (LTC)?

See 5.4

5.3 Are there additional costs to users associated with using any public health and social services?

See 5.4

5.4 What is the estimated public / private mix in health and social care?

As can be deducted from Table 25, the government pays 75.9 %. Supplementary private insurances and health insurance companies amount for 4.6 %. The patient him- or herself is responsible for 19.1 % of the expenses. The employers pay 0.4 %. These are compensations that a lot of larger companies and multinationals award directly to their personnel.

Table 25: Expenditure for health care: government, patient, employer and private (in millions of euro and in %) (1998-2001)

	1998		1999		2000		2001	
	#	%	#	%	#	%	#	%
Government	**14,740.70**	**72.2**	**15,803.60**	**75.7**	**16,792.70**	**75.6**	**17,879.90**	**75.9**
Social security	12,263.00	62.5	13,108.40	62.8	13,862.60	62.4	14,877.30	63.2
Federal government	1,326.30	6.8	1,364.60	6.5	1,451.30	6.5	1,354.50	5.8
Regions and communities	885.10	4.5	1,061.50	5.1	1,150.90	5.2	1,315.50	5.6
Local governments	266.30	1.4	269.10	1.3	327.90	1.5	332.60	1.4
Patient	**3,946.23**	**20.1**	**4,093.52**	**19.6**	**4,365.28**	**19.7**	**4,491.51**	**19.1**
Out-of-pocket	2,730.54	13.9	2,840.98	13.6	3,094.55	13.9	3,177.19	13.5
Personal contribution	1,262.95	6.4	1,296.40	6.2	1,314.02	5.9	1,363.40	5.8
Refunding of personal contribution	-47.27	-0.2	-43.86	-0.2	-43.29	-0.2	-49.09	-0.2
Employer	**99.16**	**0.5**	**99.58**	**0.5**	**100.00**	**0.5**	**100.42**	**0.4**
Private	**819.82**	**4.3**	**888.80**	**4.3**	**953.52**	**4.3**	**1,077.17**	**4.6**
Private insurance	290.20	1.7	356.30	1.7	392.20	1.8	453.30	1.9
Health insurance companies	529.62	2.5	532.50	2.5	561.32	2.5	623.87	2.6
Total	**19,605.90**	**100**	**20,885.50**	**100**	**22,211.50**	**100**	**23,549.00**	**100**

Source: BVVO, 2004

Tables 26 and 27 show the expenses by the government, health insurance companies and the personal contribution by the patient (only included in the first table) split by sub-sector. More than 90 % of the total expenses are for direct or non-direct medical care. 10 % is for administration and management, training and research and investments. Hospital care is the most important expenditure entry, followed by home care and ambulatory care (23.9 %) and medication (16.1 %). Also, it is important to note that the expenses for palliative care are 7 times as big in 2001 as in 1998. The expenditure for elderly care also rose significantly.

Table 26: Government expenditure, expenditure by health insurance companies and personal contributions of patients per care sector in millions of euro (1998-2001)

	1998	1999	2000	2001
I. Social service sectors	**14,875.8**	**15,691.1**	**16,780.0**	**18,108.6**
1. Hospital care	5,094.1	5,417.4	5,719.5	6,143.0
2. Home care and ambulatory care	3,998.4	4,138.0	4,382.3	4,671.4
3. Medical-technical diagnostic services	1,452.6	1,489.9	1,609.1	1,718.6
4. Pharmaceutical help	2,543.8	2,737.1	2,954.7	3,158.2
5. Mental health care	356.3	353.0	377.5	440.8
6. Elderly care	713.1	791.0	891.0	1,034.3
7. Palliative care	2.3	2.3	6.3	15.1
8. Remaining health care	364.3	398.7	437.6	481.1
9. Other costs related to illness	266.0	276.0	315.8	377.7
10. Preventive care	84.9	87.7	86.1	68.5
II. Care supporting components	**1,434.7**	**1,723.3**	**1,609.5**	**1,465.0**
A. Management and administration	1,198.2	1,460.4	1,307.2	1,181.0
B. Training and research in health care	56.7	64.3	66.2	75.7
C. Investments in health care	179.9	198.6	236.0	208.4
Total expenditure	**16,310.6**	**17,414.4**	**18,389.4**	**19.573.7**

Source: BVVO, 2004

Table 27: Government expenditure and expenditure by health insurance companies per care sector in % (1998-2001)

	1998	1999	2000	2001	1999 / 1998	2000 / 1999	2001 / 2000
I. social service sectors	**91.2**	**90.1**	**91.2**	**92.5**	**6.5**	**5.4**	**7.0**
1. Hospital care	31.2	31.1	31.1	31.4	7.4	4.1	6.5
2. Home care and ambulatory care	24.5	23.8	23.8	23.9	4.5	4.4	5.7
3. Medical-technical diagnostic services	8.9	8.6	8.8	8.8	3.5	6.5	5.9
4. Pharmaceutical help	15.6	15.7	16.1	16.1	8.6	6.4	6.0
5. Mental health care	2.2	2.0	2.1	2.3	0.0	5.4	15.8
6. Elderly care	4.4	4.5	4.8	5.3	12.0	11.0	15.1
7. Palliative care	0.0	0.0	0.0	0.1	-1.7	175.1	137.2
8. Remaining health care	2.2	2.3	2.4	2.5	10.5	8.2	9.0
9. Other costs related to illness	1.6	1.6	1.7	1.9	4.8	12.8	18.5
10. Preventive care	0.5	0.5	0.5	0.3	4.3	-3.1	-21.2
II. Care supporting components	**8.8**	**9.9**	**8.8**	**7.5**	**21.3**	**-7.9**	**-9.8**
A. Management and administration	7.3	8.4	7.1	6.0	23.0	-11.8	-10.4
B. Training and research in health care	0.3	0.4	0.4	0.4	14.5	1.5	13.3
C. Investments in health care	1.1	1.1	1.3	1.1	11.5	17.2	-12.5
Total expenditure	**100**	**100**	**100**	**100**	**7.8**	**4.1**	**5.5**

Source: BVVO, 2004

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

In 1998, the average cost for a one-person room in a rest home or nursing home was € 991.57 per month. Since then, prices have only risen. Considering that in 1998, half of the elderly population received a pension between € 619.73 and € 867.63, this is a very high price (http://www.wvc.vlaanderen.be/rusthuisinfofoon/vragen/kostprijs.htm). Also, figures show that the daily personal cost for living in a nursing home has risen considerably more than the average workers' pension has (Truyers, 2001).

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

About 35 % of rest home care, 45 % of nursing home care, 80 % of home care services and 100 % of home nursing are financed by public means (Pacolet, 2001). The funding is a mix of taxation and social contributions.

5.7 Funding of family carers

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

The federal government gives compensations for diminished or lack of ability to do things independently to people older than 65 years of age. The amount depends on the income of the dependent person and the person(s) he or she forms a household with. To establish whether someone suffers from diminished or lack of ability to do things independently, the following aspects are taken into account:

- the ability to move oneself
- the ability to prepare and to eat food
- the ability to take care of personal hygiene and to dress oneself
- the ability to maintain one's house and to do household work
- the ability to live without supervision, to be conscious of danger and to be able to avoid danger
- the ability to communicate and for social contact.

A medical practitioner determines for each function what difficulties the person might experience. Four answers are possible:

- no difficulties, no special efforts, no need for special aids: 0 points
- limited difficulties, limited special efforts or limited need for special aids: 1 point
- extensive difficulties, large special efforts or extensive need for special aids: 2 points
- impossible without help from other persons, or without residential care, or without a completely adapted environment: 3 points.

The points are added and according to the total, the person is categorized in one of five categories:

- 7 to 8 points: category 1
- 9 to 11 points: category 2
- 12 to 14 points: category 3
- 15 to 16 points: category 4
- 17 to 18 points: category 5

Less than 7 points gives no right to compensations. The amount of the compensations depends on the category the person is in:

Table 28: Compensations for diminished or lack of ability to do things independently per category (amounts for 01 / 07 / 2003)

	Per year	Per month
Category 1	€ 805,28	€ 67,11
Category 2	€ 3.073,95	€ 256,16
Category 3	€ 3.737,43	€ 311,45
Category 4	€ 4.400,71	€ 366.73
Category 5	€ 5.405,66	€ 450,47

Source: Ministerie van Sociale Zekerheid, 2003

The Flemish Care Insurance (only for Flanders and Brussels) provides compensations for non-medical costs for dependent people. When the person is living at home, compensations are provided for family care, the costs for purchasing or hiring aids (wheelchair, special bed, et cetera) and the costs for non-medical care given by professional home care services. When the person is living in a residential facility, compensations are provided for the cost of staying in the facility.

To receive benefits from the Flemish Care Insurance, one has to live in Flanders or Brussels and one has to be recognized as somebody who is in need of serious care, independent of age.

People who live at home can prove they are in need of serious care, by obtaining one of the following certificates:

- at least score B on the Katz-scale, scored by a home nurse
- at least 35 points on the BEL-profile scale
- at least score 15 on the medical-social scale used to establish one's rights to compensations for diminished or lack of ability to do things independently (see supra)
- at least score C on the evaluation scale used to confirm the request for compensations for day care or for a short stay in a residential facility

The benefits amount to € 90 (since 01 / 01 / 2003) for home care (formal and informal) per month.

Some local authorities (municipalities) and / or the Public Centre for Social Work in those municipalities give extra compensations to people caring for a family member at home. The amount varies from € 49.75 per year to € 74.36 per month. Every municipality has its own regulations. In some, it is only intended for care for people older than 65 years, in others, there is no age limit.

Three provinces in Flanders (East-Flanders, Antwerp and Limburg) also give compensations to people caring for somebody at home. In East-Flanders, the person needs to be a close family member of at least 75 years of age and in

need of care or help with activities of daily living. To be considered in need of care, the elderly person had to have two of the following conditions:

- to be bedridden
- not to be able to move oneself without help
- to need help for eating or for using the bathroom
- to be incontinent

or the person in question has to suffer from dementia or from a psychological illness.

The compensations are only awarded if the income of the main carer does not exceed a certain limit and amount to € 2.47 per day, with a maximum of € 619.73 per year.

In Antwerp, the elderly person in need of care needs to be

- 75 years of age or older
- have limited ability to move himself or herself
- need help feeding and with hygiene or be chronically incontinent
- or younger than 75 years of age, but be disoriented in space and time.

There is also a limit to the income of the main carer. The compensations amount to € 3.71 per day, with a maximum of 120 days per year.

In Limburg, compensations are given to people who take care of an elderly person at home. However, compensations are only given to inhabitants of municipalities that also give compensations. In this way, the province wants to stimulate the municipalities to give compensations. Moreover, the elderly person taken care of must be

- at least 65 years of age
- be entitled to compensations for diminished or lack of ability to do things independently in category 3 (see supra)
- not be entitled to benefits from the Flemish Care Insurance.

The compensations amount to 60 % of the total amount the caregiver yearly received from the municipality in the year preceding the application. There is a maximum limit of € 123.95 if one elderly person is taken care of and € 185.92 if two elderly persons are taken care of.

In some regions, the Health Insurance also gives compensations to carers. These compensations are either based on costs that have been made and / or on the degree of the care needed.

	Attendance allowance	Carers´ allowance	Care leave
Restrictions	Yes (see supra)	Yes (see supra)	Yes (see supra)
Who is paid?	Person in need of care	Person in need of care and family carer	Family carer
Taxable	No	Yes	Yes
Who pays?	Compensations for diminished or lack of ability to do things independently	Care insurance (only Flanders and Brussels)	Time credit, Care leave (different forms, see supra)
Pension credits	No	No	No
Levels of payment / month	See supra § 5.7.1	See supra § 5.7.1	See supra § 2.2.3
Number of recipients in 2002		115,392 in 2002	

5.7.2 Is there any information on the take up of benefits or services?

At the regional level, data about the Flemish care insurance (also applicable for Brussels) show that between October 1st, 2001 and December 31st, 2002 115,392 people received benefits from this insurance. 91.937 of those people were older than 65 years. About three out of four applications concern home care. This implies that about 69,000 people older than 65 years received benefits to pay for home care (by professional or by informal caregivers).

Table 29: The number of people receiving care benefits from the Flemish care insurance per age group in 2002

Age	Number of people receiving care benefits	Age	Number of people receiving care benefits
0-18	2.562	75-79	17.097
19-25	1.548	80-84	20.354
< =25	**4.110**	85-89	18.512
26-44	6.429	90-94	13.338
45-64	12.916	95-99	3.971
26-64	**19.345**	> = 100	518
65-69	6.862	**> = 65**	**91.937**
70-74	11.285	**Total**	**115.392**

Source: Het Vlaams Zorgfonds
(http://www.wvc.vlaanderen.be/zorgverzekering/Statistieken/statistieken.htm)

5.7.3 Are there tax benefits and allowances for family carers?

There are no tax benefits. Allowances were described in § 5.6.1.

5.7.4 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

No.

5.7.5 Carers' or Users' contribution to elderly care costs

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner	X[9]	X				
Specialist doctor	X	X				
Psychologist			X			
Acute Hospital	X	X				
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)		X				
Day hospital		X				
Home care for terminal patients	X					
Rehabilitation at home	X	X				
Nursing care at home (Day / Night)		X				
Laboratory tests or other diagnostic tests at home	X	X				
Telemedicine for monitoring	Not available					
Other, specify						

[9] Some health services are completely free for some categories op people (widows and widowers, orphans, people with a handicap, people who already paid a substantial amount of personal contributions…)

b.Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home		X				
Temporary admission into residential care / old people's home in order to relieve the family carer		X				
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)						
Laundry service			X			
Special transport services		X	X	X		
Hairdresser at home			X			
Meals at home		X	X	X		
Chiropodist / Podologist		X	X			
Telerescue / Tele-alarm (connection with the central first-aid station)						X
Care aids		X	X			X
Home modifications			X			
Company for the elderly			X[10]			
Social worker	X					
Day care (public or private) in community center or old people's home		X	X	X		
Night care (public or private) at home or old people's home		X	X	X		
Private cohabitant assistant ("paid carer")	X / -[11]		X			
Daily private home care for hygiene and personal care		X	X	X		X
Social home care for help and cleaning services / "Home help"		X	X	X		X
Social home care for hygiene and personal care		X	X	X		X
Telephone service offered by associations for the elderly (friend-phone, etc.)	Not available					
Counselling and advice services for the elderly	Not available					
Social recreational centre	X					
Other, specify						

[10] Most of these services are volunteer work and are completely or almost completely for free.

[11] This is in principle only available for people with a handicap (personal assistance budget system) under 65 years of age, but there are some people older than that age that receive such a budget.

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring		X[12]				
Telephone service offered by associations for family members	Not available					
Internet Services	Not available					
Support or self-help groups for family members	X					
Counselling services for family carers[13]	X	X	X			
Regular relief home service (supervision of the elderly for a few hours a day during the week)	x[14]	X				
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)						
Assessment of the needs	X					
Monetary transfers	Not available					
Management of crises	X					
Integrated planning of care for the elderly and families at home or in hospital	X		X			
Services for family carers of different ethnic groups	X / –[15]					
Other, specify						

[12] These courses are subsidized by government and thus cheaper than the actual cost.
[13] Offered by support groups of family members and by self-help groups
[14] Only in the Flemish Region. See § 4.1.2.7
[15] If available, then only in very local initiatives by volunteers or self-help groups.

6 Current trends and future perspectives

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

The **social statute of the family carer** is an important issue for 'pressure groups' of carers. They want legislation that allows family carers who leave their job in order to be able to care for someone, to keep their social security rights. In that way; they for example would not lose pension rights. The government has complied to some of their demands (e.g. time credit and other kinds of leave, see supra), but their still is not a full social statute for the family carer.

Another important policy issue for family carers is the **affordability of care** for the elderly person and the caregiver. There is demand for an extension of the 'maximum invoice' system, since some costs are not included in the system as yet (e.g. nursing care by a professional nurse at home). Also, there is concern about the increase in the prices (personal contributions) for residential care and the eventual reclamation from (grand)children if the elderly person cannot (fully) afford residential care.

Carer abuse is an issue since 1998 (see § 1.11) Since then, a Central Report Point for Elderly Abuse (Centraal meldpunt ouderenmis(be)handeling) was installed in the Flemish Community. There are also a couple of local antennas. In the French speaking Community, the Centre d'Aide aux Personnes âgées maltraitées (CAPAM) (Centre for help for mistreated elderly people) was installed.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

The **demographic evolution and the affordability of pensions and care** is policy issue. It is feared that the pressure on the balance between offer and demand of care will become too high in the following decades. To establish a reserve fund for the cost of pensions, the Silver Fund was established at a federal level (see supra).

At the level of the communities and the regions, a lot of attention is given to home care as opposed to residential care. The program norms for care services (i.e. the programmed growth of those services) are being increased yearly, but they are not always realized in practice because of budget deficits, or other problems. Different political parties also have different views on the

responsibility of the government and on the mix between public and private services. There however seems to be a consensus on the fact that the enforcement of family care and in-home care in general is the best option.

In care for persons with a handicap, the trend most certainly is towards more cash. The personal assistance budget system allows people with a handicap to recruit assistants and to draw up their own care plan and care mix. The evolution in elderly care is toward more demand-oriented care and towards more cash as well, but budgetary constraints might slow down this process.

6.3 What is the role played by carer groups / organisations, "pressure groups"?

It is hard to tell what the actual influence of pressure groups is, but it is without doubt that they have brought a number of issues – and most of all the social statute of the family carer – into the attention of policy makers.

6.4 Are there any tensions between carers' interests and those of older people?

Formally, there are no tensions. However, carers and older people are confronted with ethical dilemmas and the decisions they make, may have differential impacts on the caregivers and the elderly people they care for.

Families are confronted with the dilemma: care for the elderly person versus a life without the duty to provide care. Values such as care, autonomy and privacy, participation and solidarity are at stake and those values can be realized on behalf of the elderly person in the context of home care. But when a family opts for home care, their decision implies a number of restrictions with respect to their own personal lifestyles. At first sight, such an option represents something of a violation of the caregivers own self-care and autonomy. It goes without saying that home care can be enormously taxing and unavoidably implies that many other meaningful options are no longer available to the various members of the family. Research has shown that certain families are confronted with greater burdens than others. Family members who care for a person with a low degree of social function tend themselves to exhibit a high degree of avoidance behaviour, to lack openness towards others, to have few social contacts, and to maintain that important elements in the care of the client are not being realized (De Rick et al., 2000).

On closer inspection, however, it would seem that care for a family member need not necessarily imply an infringement of the self-care and autonomy of the remaining family members. Where the latter freely opt for home care and experience their option as meaningful, this can represent a valuable enhancement of their sense of autonomy. As a matter of fact, the same research has shown that family members can experience the care process in a highly

positive manner: the development of closer bonds between parents and children, brothers and sisters, the experience of the concern and sympathy of friends, and the acquisition of a more positive attitude with respect to individuals with mental health problems (De Rick et al., 2000, Bauduin, 2002).

Formal caregivers are also faces with a dilemma in their relationships with the elderly person and with his or her family: the best care for the elderly person versus the best care for the caregivers? It is far from easy to serve as a caregiver for the client *and* his or her family, since the best interests of both are not always the same. Caregivers are trained to uphold the axiom that their service is aimed in the first instance at the client, with a view to promoting his or her autonomy, and only in the second instance at the family. The best of care for the client, however, also implies the best of care for the members of his or her family and the support of his or her social network.

Policy makers are similarly faced with a significant dilemma: setting aside sufficient budgetary resources for residential and formal care for elderly people versus the provision of further financial incentives for informal care? It is a widely known fact that economic considerations play a primary role in this debate: government is obliged to reduce its spending or at least endeavour to maintain some degree of balance in its health care and social services budget. Values such as justice and solidarity are at stake when one is confronted with this dilemma. Distributive justice insists that people be treated equally when they are equal and unequally when they are unequal for one reason or another or when they find themselves in a situation of inequality. The latter certainly applies to those elderly people whose situation is clearly not equal to that of the average citizen in terms of their care requirements. These persons require quality care appropriate to their individual needs.

It remains a fact, however, that care must be accessible and affordable for all. Health care and the provision of social services are such valuable commodities that society is not at liberty to submit it (completely) to the laws of the market. Its best option is thus to include it as an essential element of the solidarity exercised by society as a whole. It would thus be irresponsible for society to attach a different price tag to the various forms of care and thereby force the client to absorb extra costs in line with the extent of the required care (Bauduin, 2002).

6.5 State of research and future research needs (neglected issues and innovations)

There is a need for good scientific research into the needs and expectations of (future cohorts of) elderly people. In that way, it can – among other things – be determined which needs are most urgent. Policy makers can than spend the limited funds on what is a priority. Good scientific research can also offer insight in the problems elderly people and their informal caregivers are confronted with.

Belgian researchers are quite active in the domain of elderly people and elderly care. The subjects studied are diverse, but can be categorized into four domains: healthy elderly people and processes of ageing, illness and good health in elderly people, care for elderly people and gerontological methodology. Most studies however concentrate on analyses of specific problems and few are based on a survey of the wishes, care needs and expectations of the elderly. Also, there is a lack of research into the implementation and evaluation of new knowledge, new developments and new applications (Van Audenhove et al., 1999). There is a need for more action-research, aimed at supporting practice, via stepped-care and shared-care methodologies.

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

The internet plays an important role in contemporary social life. It offers a lot of opportunities for elderly people and their caregivers, but it also can cause new inequalities, since those who do not know how to use it or have no access to it, are in a weaker position that those that do. A lot of information on rights and possibilities for caregivers can be found on the net. It has thus become quite an important source of information. Initiatives such as www.seniorweb.be try to open up these possibilities by providing information on their website, by organizing computer courses for elderly people and by organizing internet panel discussions on topics that concern elderly people and their caregivers.

6.7 Comments and recommendations from the authors

no comments and / or recommendations provided

7 Appendix for the National Background Report for Belgium

7.1 Socio-demographic data

Table 30: Number of births, per region and per sex (1980-2002)

	1980	1990	2000	2001	2002
Belgium	124.794	123.554	114.883	114.172	111.225
Boys	63.917	63.304	58.790	58.243	57.044
Girls	60.877	60.250	56.093	55.929	54.181
Region of Brussels	12.520	12.852	13.626	14.513	13.929
Boys	6.384	6.596	7.038	7.351	7.078
Girls	6.136	6.256	6.588	7.162	6.851
Flemish region	72.491	69.492	61.877	60.645	59.725
Boys	37.248	35.601	31.572	31.013	30.683
Girls	35.243	33.891	30.305	29.632	29.042
Walloon Region	39.783	41.210	39.380	39.014	37.571
Boys	20.285	21.107	20.180	19.879	19.283
Girls	19.498	20.103	19.200	19.135	18.288

Source: NIS, Population Statistics

7.1.1 Profile of the elderly population-past trends and future projections

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years

Table 31: Life expectancy at birth in Belgium in 2001 (in years)

	Men	Women
Belgium	75,42	81,67
Region of Brussels	75,34	81,36
Flemish Region	76,44	82,30
Walloon Region	73,61	80,66

Source: NIS, Population statistics

Table 32: Evolution of life expectancy at birth (1995-2001) (in years)

	1995	1996	1997	1998	1999	2000	2001
Men and women							
Life expectancy at birth	77,35	77,71	77,91	77,99	78,16	78,29	78,59
Change compared to the previous year	+0,07	+0,36	+0,20	+0,08	+0,17	+0,13	+0,30
Men							
Life expectancy at birth	73,91	74,34	74,65	74,81	74,87	75,08	75,42
Change compared to the previous year	+0,03	+0,43	+0,31	+0,16	+0,06	+0,21	+0,34
Women							
Life expectancy at birth	80,73	81,01	81,08	81,08	81,38	81,42	81,67
Change compared to the previous year	+0,12	+0,28	+0,07	0,00	+0,30	+0,04	+0,25

Source: NIS, Population Statistics

At age 65, men can expect 16.24 more years and women 20.23 years (figures for 2001). On average, the life expectancy for men and women is 83.42 years at the age of 65 (N.I.S.).

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

Table 33: Population prognosis 2000-2050: demographic measures (situation at December 31st of each year)

	2000	2010	2020	2030	2040	2050
Ageing (a)	93,10	106,82	128,72	147,13	156,01	159,63
Dependency (b)	83,09	85,33	94,22	106,37	109,99	112,00
Dependency of the elderly (c)	40,06	44,07	53,03	63,32	67,03	68,86
Number of active people per elderly person (d)	2,50	2,27	1,89	1,58	1,49	1,45
Ageing of potentially active people (e)	94,64	111,77	106,77	102,89	105,47	103,32
Ageing within ageing (f)	16,75	21,52	20,79	22,38	28,07	31,89
Conjunctural indicator of fertility (g)	1,62	1,66	1,68	1,70	1,72	1,74
Masculinity ratio (h)	95,76	96,18	96,70	96,96	96,91	97,25
Average age	39,29	40,89	42,28	43,54	44,54	44,94
Life expectancy at birth	78,34	80,32	82,08	83,69	85,11	86,38

Source: NIS, Population Statistics
(a) The ratio of the number of people older than 60 years and the number of people between 0 and 19 years (expressed as a percentage).

(b) The ratio of the number of people most dependent (younger than 19 years and older than 60 years) and the number of people usually active in the labour market (between 20 and 59 years of age) (percentage).
(c) Part of the previous ratio, being the part of the elderly people (percentage).
(d) The inverse of the previous ratio.
(e) If we divide the potentially active people in two age groups of 20 years, then ratio of the age group of 40 to 59 years and the age group of 20 to 39 years is a measure for the ageing of the potentially active (percentage).
(f) The ratio of the people older than 80 years of age and the age group of people of 60 years and older (percentage).
(g) The number of children a woman could expect if she would be exposed to the expected fertility. The measure does not take account of the evolution in fertility during the lifetime of a certain woman.
(h) The number of men for each woman (percentage).

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Table 34: Marital status of people 65 and older, per age group and per sex (2001)

Sex	Age group	Single		Married		Divorced		Widow(er)		Total	
		#	%	#	%	#	%	#	%	#	%
Men	65-69	14,665	6.33	185,928	80.30	15,886	6.86	15,071	6.51	231,550	100
	70-74	13,114	6.27	163,735	78.24	10,301	4.92	22,132	10.57	209,282	100
	75-79	9,325	5.01	114,329	73.74	5,096	3.29	26,287	16.96	155,037	100
	80-84	4,687	5.44	56,851	66.04	2,284	2.65	22,268	25.87	86,090	100
	85-90	1,788	5.81	15,693	50.94	582	1.89	12,746	41.37	30,809	100
	90-94	691	6.23	3,741	33.75	169	1.52	6,485	58.50	11,086	100
	95+	134	7.17	353	18.88	27	1.44	1,356	72.51	1,870	100
Women	65-69	12,499	4.79	169,259	64.83	18,443	7.06	60,896	23.32	261,097	100
	70-74	14,334	5.42	140,836	53.27	13,656	5.17	95,544	36.14	264,370	100
	75-79	14,767	6.45	87,022	38.01	9,005	3.93	118,162	51.57	228,956	100
	80-84	10,774	6.90	37,022	23.71	4,794	3.07	103,572	66.32	156,162	100
	85-90	6,316	8.19	7,888	10.23	2,015	2.61	60,906	78.98	77,125	100
	90-94	3,384	8.69	1,558	4.00	962	2.47	33,069	84.85	38,973	100
	95+	1,021	10.23	119	1.19	219	2.19	8,624	86.39	9,983	100
Total	65-69	27,164	5.51	355,187	72.10	34,329	6.97	75,967	15.42	492,647	100
	70-74	27,448	5.79	304,571	64.30	23,957	5.06	117,676	24.84	473,652	100
	75-79	24,092	6.27	201,351	52.44	14,101	3.68	144,449	37.62	383,993	100
	80-84	15,461	6.38	93,873	38.75	7,078	2.92	125,840	51.95	242,252	100
	85-90	8,104	7.51	23,581	21.85	2,597	2.41	73,652	68.24	107,934	100
	90-94	4,075	8.14	5,299	10.59	1,131	2.26	39,554	79.01	50,059	100
	95+	1,155	9.74	472	3.98	246	2.08	9,980	84.20	11,853	100

Source: NIS, Ecodata (www.ecodata.mineco.fgov.be) & Mestdagh and Lambrecht, 2003

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups

Table 35: Households counting 1,2,3,4 or 5 and more people, by gender and age group of reference person, in percent (2001)

Men					
Age group	Single HH	2-person HH	3-person HH	4-person HH	5+ person HH
65-69	14.83	67.13	13.13	3.06	1.84
70-74	16.75	69.66	10.34	2.04	1.22
75-79	20.32	69.02	8.25	1.48	0.94
80-84	25.92	65.20	6.96	1.21	0.71
85-89	38.63	54.16	5.63	1.01	0.58
> 90	53.06	41.29	4.21	0.96	0.48
Women					
Age group	Single HH	2-person HH	3-person HH	4-person HH	5+ person HH
65-69	78.57	16.60	3.12	0.96	0.76
70-74	82.29	13.90	2.43	0.79	0.59
75-79	84.70	12.07	2.05	0.69	0.50
80-84	86.30	10.84	1.89	0.55	0.42
85-89	87.41	10.03	1.80	0.45	0.30
> 90	86.23	10.92	2.10	0.42	0.33

Source: NIS, population census data (Mestdagh & Lambrecht, 2003)

7.1.1.5 Urban / rural distribution by age

Not available and not relevant

7.1.1.6 Disability rates amongst > 65 year-olds. Estimates of dependency and needs for care

Table 36: Disability free life expectancy in 2001, by age and gender

Age	Men	Women
65	7.77	9.55
70	5.72	7.02
75	4.07	5.10
80	2.45	3.39
85	1.37	1.68
90	0.27	1.10

Source: Mestdagh & Lambrecht, 2003b

Table 37: Mobility handicap (% of population) by age group and gender, 2001

Age group	Men			Women		
	House / yard	Chair	Bed	House / yard	Chair	Bed
65-74	4.9	2.6	0.1	8.9	3.3	0.8
75-84	6.2	10.6	2.4	20.8	6.3	0.4
85+	12.6	30.1	8.6	25.7	19.7	10.5

Source: Health Interview Survey, 2001 (Mestdagh & Lambrecht, 2003b)

Table 38: SF36 score for physical functioning by age group and gender, 2001*

Age group	Men	Women
65-69	79.6	76.5
70-74	77.2	61.8
75-79	68.0	55.2
80-84	47.3	45.2
85+	35.3	23.0

* The SF36 index of physical functioning takes into account the degree in which a person is limited in executing 10 different activities. The 10 activities are: limitations in case of vigorous activities, limitations in case of moderate activities, limitations in case of lifting or carrying groceries, limitations in case of climbing several flights of stairs, limitations in case of climbing one flight of stairs, limitations in case of bending, kneeling or stooping, limitations in case of walking more than one kilometer, limitations in case of walking a few hundred meters, limitations in case of walking one block, limitations in case of bathing or clothing oneself.
Source: Health Interview Survey, 2001 (Mestdagh & Lambrecht, 2003b)

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same for poorest 20 % income groups

Table 39: % of individuals above and beneath the poverty limit by age group (60 % median, standardized monthly income)

Age group	% not poor	% poor
0-15	85.77	14.23
15-24	79.66	20.34
25-49	88.53	11.47
50-64	89.55	10.45
65+	85.45	14.55

Source: Health Interview Survey, 2001 + Calculations by OASeS (http://www.ua.ac.be/main.asp?c=*OASES)

7.1.1.8 % > 65 year-olds in different ethnic groups

Table 40: Men and women older than 65 year per nationality (continent)

	Men	Women	Total
European (non-Belgian)	40,182	45,009	85,191
Asian	433	545	978
African	3,836	3,492	7,328
North-American	453	390	843
South-American	73	156	229
Oceanian	14	13	27
Unknown or stateless	617	730	1347
Total	**45,608**	**50,335**	**95,943**

We should however keep in mind that quite a lot of first generation immigrants from Italy, Greece, Turkey, Morocco and a few other countries took the Belgian nationality. They belong to a different ethnic group, but are not in the figures in Table 40.

7.1.1.9 % Home ownership (urban / rural areas) by age group

68 % of the homes were owned by their occupiers in 2001. That is 12 % more than in 1991. The increase is largest in the Flemish Region (+14 %). In the largest cities however, less than half of the people owns the home they live in. There are least owners in Brussels.

Table 41: Home ownership in 1991 and 2001, and the evolution 2001 / 1991

	1991		2001		Evolution 2001 / 1991
	#	%	#	%	
Belgium	2.417.671	65,4 %	2.715.228	68,0 %	+12,3 %
Flemish Region	1.462.210	69,2 %	1.668.886	72,6 %	+14,1 %
Walloon Region	805.169	67,1 %	883.328	68,1 %	+9,7 %
of which German Speaking Community	15.958	65,1 %	17.686	66,5 %	+10,8 %
Brussels Region	150.292	39,0 %	163.014	41,3 %	+8,5 %
Total for the 5 largest cities	380.562	44,8 %	409.631	47,8 %	+7,6 %
Brussels	150.292	39,0 %	163.014	41,3 %	+8,5 %
Antwerp	96.058	46,8 %	104.591	53,1 %	+8,9 %
Ghent	45.651	48,3 %	51.878	53,2 %	+13,6 %
Charleroi	47.627	59,1 %	48.736	58,2 %	+2,3 %
Liège	40.934	49,1 %	41.412	49,3 %	+1,2 %

Source: NIS

7.1.1.10 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

In 2001, 73 % of the homes had central heating. 4 % of the homes had no indoor plumbing. 83 % of the families had a telephone and 70 % had a mobile phone (NIS).

7.2 Examples of good or innovative practices in support services

Integrated Services for Home Care (GDTs) are a federal initiative. These GDTs help family carers by organizing multi-disciplinary consultation and by helping them to draw up a realistic care plan that specifies the tasks of each (formal and informal) carer.

The Cooperation Initiatives in Home Care (SITs) were initiated by the Flemish government in 1990. Such an initiative brings together different carers – professionals, volunteers, family members, … — to work together, to confer and to make agreements. The goal is to coordinate the help the person with dependencies needs. The emphasis is on a holistic approach of the person and on continuity and good quality of care. One SIT per region of 25,000 inhabitants can be subsidized. The Flemish government plans on restructuring and renaming the SITs into SELs (Cooperation Initiatives First Line Health Care). These should coincide or cooperate closely with the GDTs financed by Federal government.

The Expertise-centres for Dementia are subsidized by the Flemish government. They give information and counselling to people suffering from dementia and their families and carers. Their vision is emancipatory: they want to help and reinforce the network around the person with dementia They also organize lectures and training for formal and informal carers.

Small-scale normalized living for people suffering from dementia ('Cantous' in the Walloon Region, 'kleinschalig genormaliseerd wonen' in the Flemish Region)

Scientific research showed that living in a familiar, safe and secure environment, supporting self-care, attention for the perception of the person, or encouraging to participate in the broader society, significantly increase the life quality of a person with dementia. This encouraged several people to search for alternative forms of care and for deinstitutionalizing care for people suffering from dementia. These kind of projects started in the 1980's, and now find more and more followers. Although they organized their project in different ways, their basic assumptions are the same. Dementia is seen as a pervasive for the person with dementia and for his or her environment. Life should still be worth living and this should be shown in the way people are treated: with respect, attention, personalized, social, humane, recognizable and secure, integrated in the surrounding neighbourhood. Both initiators were convinced that a

small scale living environment would benefit a person with dementia, physically as well as emotionally. In our very cognitively oriented society, we tend to forget that a person suffering from dementia is more then his or her illness and that emotional consciousness is possible, even when our memory fails us. The initiators were convinced that a 'house in the row' would offer more chances of a continuing high quality of life than the classical nursing home concept. This however does not mean they want all nursing homes abolished. It means they wanted to offer a proper alternative for those people that rather not stay in a nursing home. The projects are demand-oriented, starting from the strengths and possibilities of the persons with dementia. They are stimulated to use those possibilities to the fullest. Staff tries to empathize with the inhabitants as much as they can, and to communicate from within that empathy. The participation of the inhabitants and of family members is crucial. The organization of care is subordinate to these principles and to the realization of a high quality of life for the residents.

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