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Exploring the impact of austerity-driven policy reforms on the quality of the long-term care provision for older people in Belgium and the Netherlands

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ABSTRACT

In this case study, European quality benchmarks were used to explore the contemporary quality of the long-term care provision for older people in the Belgian region of Flanders and the Netherlands following recent policy reforms. Semi-structured qualitative interviews were conducted with various experts on the long-term care provision. The results show that in the wake of the economic crisis and the reforms that followed, certain vulnerable groups of older people in Belgium and the Netherlands are at risk of being deprived of long-term care that is available, affordable and person-centred. Various suggestions were provided on how to improve the quality of the long-term care provision. The main conclusion drawn in this study is that while national and regional governments set the stage through regulatory frameworks and financing mechanisms, it is subsequently up to long-term care organisations, local social networks and informal caregivers to give substance to a high quality long-term care provision. An increased reliance on social networks and informal caregivers is seen as vital to ensure the sustainability of the long-term care systems in Belgium and in the Netherlands, although this simultaneously introduces new predicaments and difficulties. Structural governmental measures have to be introduced to support and protect informal caregivers and informal care networks.

Introduction

With the baby boom generation – the large cohort of citizens born after the Second World War, between 1946 and 1964 – gradually reaching retirement age, the beginning of an unprecedented shift in Europe's demographic composition is marked. Populations in Europe are ageing, as both the absolute number of older citizens and the relative number of older citizens (i.e. the proportion of older citizens as a percentage of the total population) are steadily growing (European Commission, 2012; Rechel et al., 2013). This rise in the number of senior citizens within Europe will inevitably lead to a significant increase in the number of frail older people with functional disabilities and limitations, in turn leading to an increasing demand and need for long-term social and medical care (Bonneux, Van der Gaag, & Bijwaart, 2012; Christensen, Doblhammer, Rau, & Vaupel, 2009; Ferri et al., 2005; Karim-Kos et al., 2008; Lafortune & Balestat, 2007; Puts, Deeg, Hoeymans, Nusselder, & Schellevis, 2008). The demographic changes will also lead to a decreasing availability of potential formal and informal caregivers (Rechel, Doyle, Grundy, & Mckee, 2009), and many contemporary financing mechanisms for long-term care will no longer be sustainable due to decreasing financial contributions to social insurance schemes from a gradually shrinking professional workforce

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(European Commission, 2013). In addition to the aforementioned developments, most countries in Europe are currently also dealing with austerity measures resulting from the recent economic crisis, exacerbating the strain on health systems further and necessitating critical evaluation of the way long-term care services are organised and financed (European Commission, 2015; Geerts, Willemé, & Mot, 2012; Swartz, 2013). In an attempt to ensure the sustainability of their long-term care systems, several European countries have recently implemented fundamental long-term care reforms (European Commission, 2014a), whereas in some other European countries similar reforms are currently under consideration (European Commission, 2015). However, one challenge when implementing such austerity-driven reforms, is maintaining an adequate level of quality of the care provision (European Commission, 2014a). Assessing how recent policy reforms throughout Europe have impacted the quality of the long-term care provision, has proven to be not an easy task, as quality measurement in long-term care lags some way behind quality measurement in other healthcare sectors (European Commission, 2014a). This is partly due to heterogeneity in the way long-term care systems for older people are structured across Europe (Genet et al., 2011), and the lack of common definitions of long-term care and its constituent parts of social and medical care and the borderline between them (European Commission, 2014a). Furthermore, a substantial share of long-term care is provided in people's own homes by informal caregivers, making it difficult for national governments to comprehensively and adequately monitor the quality of the provided care (European Commission, 2014a). Lastly, there seems to be a lack of consensus within Europe on how to conceptualise quality in the field of long-term care (European Commission, 2014a). Consequently, the current academic literature provides us with a fragmented picture of quality of long-term care systems for older people in Europe (Jongen, Burazeri, & Brand, 2015).

Study objectives

The current study aims to explore the contemporary quality of the long-term care provision in the Netherlands and the Belgian region of Flanders, a country and a region where recently substantial long-term care reforms were implemented as a response to the economic crisis and the anticipated demographic changes (European Commission, 2014b, 2014c, 2014d, 2014e). In addition to the similar socio-economic characteristics and the practical advantage of a shared language, the Netherlands and the Belgian region of Flanders form an interesting basis for comparison due to their geographic position and a certain common culture and history they thus share (Jongen, Burazeri et al., 2015).

Prior to the economic crisis and the recent reforms, the long-term care systems of both Belgium and the Netherlands were seen as highly developed in terms of patient friendliness, and characterised by a high degree of public funding (Kraus, Czypionka, Riedel, Mot, & Willemé, 2011). The Netherlands used to lead the European charts in terms of public expenditure on long-term care, with governmental long-term care expenditures equalling 3.5% of GDP in 2009 (Rodrigues, Huber, & Lamura, 2012). With 1.9% of GDP spent on long-term care, Belgium was spending substantially less on long-term care than the Netherlands, although still far more than the European average (Rodrigues et al., 2012). Private expenditures on long-term care used to be relatively low in both countries and extensive support for informal caregivers was available. In the Netherlands, public social protection arrangements used to financially cover a large variety of care services for a large group of needy citizens, while in Belgium financial support was similarly offered for a large variety of care services, but for a limited group of needy citizens (Colombo, Llenia-Nozal, Mercier, & Tjadens, 2011). Rodrigues et al. (2012) found that in Belgium people aged 80+ were almost three times as likely to be at risk of poverty compared to older people in the Netherlands, and that housing costs for Belgian seniors in proportion to their income were amongst the highest in Europe. Lastly, prior to the reforms there was quite a high reliance on informal caregivers in the long-term care provision in Belgium, while the contributions of informal caregivers in the Dutch care provision were rather minimal (Kraus et al., 2011). As the reforms introduced substantial changes in the way long-term care is organised and financed in both countries, it is plausible that many of the findings of Kraus et al. (2011); Colombo et al. (2011) and Rodrigues et al. (2012) on the Dutch and Belgian long-term care systems no longer hold true.

In Belgium, the sixth state reform that came into force in July 2014, encompassed a substantial transfer of responsibilities related to older people and long-term care from the federal state to the communities, which are the regional political entities based on the linguistic division in Belgium (European Commission, 2014c). As a consequence of this decentralisation, residential facilities and cash benefit schemes for long-term care are now completely regulated at the regional level (Cès, 2014). The Belgian government's argumentation behind this shift in responsibilities is that it enables the care provision to be more efficient and better adjusted to local needs, ensuring affordable high-quality care to both citizens and those employed in the long-term care sector (European Commission, 2014c). Simultaneously, several structural cost-saving measures have accompanied recent reforms intended to limit health care expenses. In doing so, the Belgian government states that it is adhering to the country-specific recommendations of 2013 as proposed in the European Semester regarding the sustainability of public finances and social security for the elderly (Council of the European Union, 2013; European Commission, 2014c).

In the Netherlands, various responsibilities and competences for long-term care that were previously organised at national level, were transferred to the municipalities and health insurance companies on January 1, 2015 (European Commission, 2014d, 2014e). The Dutch reforms encompass that care for the most fragile and vulnerable older citizens – those in need of round-the-clock care and assistance – is now organised and financed at national level, while the municipalities are responsible for ensuring and facilitating social inclusion and independence for older citizens, supporting informal caregivers and providing household care. Health insurance companies – funded through compulsory social insurance – are tasked with the provision of nursing services, medical treatments and palliative care for older people living at home (European Commission, 2014d, 2014e). The Dutch government states that the reforms are aimed at providing more tailor-made care, delivered closer to home (European Commission, 2014e). The reforms in the Netherlands involve structural cuts of approximately 3.5 to 3.7 billion euro on expenditures on long-