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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-

term care (European Commission, 2014d, 2014e). As argued by Maarse (2013), the Dutch government has been pursuing a "retrenchment agenda" rather than an "extension agenda" in the field of long-term care since the onset of the economic crisis in 2008. Similar to Belgium, the Dutch government states that by implementing structural austerity measures, it is endorsing the country-specific recommendations within the European Semester on containing the costs of long-term care (European Commission, 2014d).

While the quality of the long-term care provision is generally substantially affected by the way long-term care is organised and financed (European Commission, 2015; Hardy, 2015), it remains unclear how exactly the recent reforms and the accompanying austerity measures in Belgium and the Netherlands have affected the quality of long-term care for older people. The recent reforms have thus created the premise for exploring and assessing the contemporary quality of the long-term care provision in both countries.

Research question

Against the background of recent long-term care reforms in Belgium and the Netherlands, the primary aim of the current study is to evaluate the Dutch and Belgian long-term care provisions in terms of adherence to established European quality benchmarks, to find out if and how the reforms have ensured and incorporated quality principles for long-term care. The research aim of this study can be translated into the following research question: "*Following the recent reforms, to what extent do the long-term care provisions in the Netherlands and Belgium meet European quality principles for long-term care*?" The intention is to obtain a profound understanding of how the reforms have affected older people in need of care, but also their families, informal caregivers and healthcare professionals. Through comparison of Belgium and the Netherlands our aim is not to determine which country "performs best", but to explore in a heuristic manner the topic of quality in the long-term care provision, generating valuable insights, theories and hypotheses on what possible further alterations to long-term care policy would be needed to improve the quality of the long-term care provision and to facilitate good practice identification and exchange in a European context.

Methods

Theoretical framework and conceptual model

As indicated by Jongen, Burazeri et al. (2015), due to the variety of definitions of long-term care for older people it is necessary to first elaborate on the exact definition that is applied in the current study. Within our study, long-term care is defined as a range of services and provisions for people who, due to mental frailty, physical frailty and/or disability over an extended time period, have become dependent on assistance to engage in daily living activities and/or are in need of permanent nursing care (European Commission, 2014a). Daily living activities can be self-care activities – such as going to the toilet, eating, getting dressed, entering and exiting the bed, moving around the house, and taking a shower or a bath (OECD, Organisation for Economic Co-operation and Development, 2005) – and instrumental daily living activities, which are activities related to the capacity to live independently, such as grocery shopping, financial management, domestic labour, cooking a meal, and using communication technologies like the internet or the telephone (European Commission, 2014a). As such, both nursing care of a more medical nature and social, personal care are incorporated in the definition of long-term care that is adhered to in the current study. Furthermore, we take into account both formal and informal caregiving when assessing the quality of the long-term care provision, and both institutional and home care will be included in the analysis. In doing so, we aim to capture the quality of the long-term care provision in a holistic manner. Finally, when using the term "older people" in the current study, we refer to those aged 65 or over (Jongen, Burazeri et al., 2015).

In order to evaluate the quality of the long-term care provision for older people, an understanding is needed of what the concept of quality actually means in this context. The topic of quality in long-term care has started gaining more attention on a European level in recent years, and fruitful attempts have since been undertaken to scrutinise and define what constitutes quality in long-term care (AGE Platform Europe, 2010; Dandi et al., 2012; European Commission, 2014a; Mot, Faber, Geerts, & Willemé, 2012). This process has been greatly facilitated by the EU-supported WeDO project (European Partnership for the Wellbeing and Dignity of Older People, 2012), which was launched in 2010; led by a coalition of 18 organisations from 12 European Union (EU) Member States, the WeDO project brought together a heterogeneous collective of stakeholders involved in the field of long-term care, with the aim of improving the quality of services for older people in need of care and assistance and to fight elder abuse through a participatory approach (European Partnership for the Wellbeing and Dignity of Older People, 2012). Through the collective efforts of these participating stakeholders, the WeDO project resulted in the development of the "European Quality Framework for Long-Term Care Services" (European Partnership for the Wellbeing and Dignity of Older People, 2012), a framework that seeks to ensure a common vision and analysis on long-term care and strives to improve the quality of life of older people in need of care and assistance on a European level. The framework furthermore aims to assist in the development of sustainable and equitable solutions to improve the wellbeing and dignity of older people by facilitating good practice exchange both between and within countries, while advocating for the inclusion of older people's opinions in deciding on how to improve the quality of the long-term care provision (i.e. a participatory approach). Of great relevance for the current study is the fact that the European Quality Framework for Long-Term Care Services endorses a list of 11 key quality principles that long-term care services for dependent older people should adhere to (European Partnership for the Wellbeing and Dignity of Older People, 2012). These quality principles are relevant for all stakeholders in the field of long-term care, and can be seen as quality benchmarks on EU, national, regional and local level (European Partnership for the Wellbeing and Dignity of Older People, 2012). While all 11 quality principles of the European Quality Framework for Long-Term Care Services were seen as pertinent and important, due to pragmatic reasons and time constraints we decided to make a more concise selection of quality principles that were to be included in our study. By focusing on a few quality principles we were able to explore

these key quality dimensions in a more detailed and comprehensive manner. We engaged in expert consultation with colleagues from AGE Platform Europe – a non-governmental organisation concerned with the wellbeing and interests of older people in Europe – to select several quality principles for inclusion in our study. AGE Platform Europe expressed a special interest in the quality principles affordability, availability and person-centredness in the context of the recent policy reforms in Belgium and the Netherlands; there were indications that these quality principles in particular were substantially affected by the austerity measures and the process of decentralisation accompanying the reforms. In the current study, we therefore adopted the three quality principles affordability, availability and person-centredness of the European Quality Framework for Long-Term Care Services (European Partnership for the Wellbeing and Dignity of Older People, 2012) to define what constitutes quality in long-term care and to evaluate the contemporary quality of the long-term care provision in Belgium and the Netherlands. Table 1 provides a brief overview of each quality principle.

Using this conceptual framework of what constitutes quality in the long-term care provision for older people, we aimed to answer our research question and meet the research objectives of the current study. Specifically, we aimed to:

- explore and describe to what extent the long-term care provisions in the Netherlands and Belgium meet the three quality principles of long-term care after recent reforms
- explore and describe how the reforms have affected older people in need of care, but also their families, informal caregivers and healthcare professionals
- explore what possible alterations in the way long-term care is organised and financed could improve the quality of the care provision in Belgium and the Netherlands

Research type and design

We operationalised our study through a qualitative research approach (Denzin & Lincoln, 2011). By adopting such a qualitative research approach, we were able to explore the complexity of the issue of quality of the long-term care provision in the specific context of the recent reforms in Belgium and the Netherlands. Furthermore, our study incorporated both exploratory and descriptive elements (Neuman, 2014). The fact that the study was conducted on a new topic in an unprecedented context asked for an exploratory approach; the specific concept of quality we adhered to (European Partnership for the Wellbeing and Dignity of Older People, 2012) had not previously been applied to evaluate the quality of the Dutch and Belgian long-term care provisions, and the reforms had created a new and unique context in which the study was conducted. Through a complementary descriptive approach we aimed to present a highly accurate picture of the specific details of the contemporary situation in both countries. The research design best fitting our research approach and research objectives was deemed to be a case study with two countries. Case study research creates opportunities to elaborate on a situation holistically, capturing its complexity while incorporating multiple perspectives (Neuman, 2014). Furthermore, case study research is highly heuristic – as it provides opportunities for further learning, discovery, or problem solving – and has high conceptual validity, meaning that it enables one to "identify concepts that are of greatest interest and move toward their core or essential meaning in abstract theory" (Neuman, 2014, p. 42).

Instruments for data collection

It appeared that the quality principles of the European Quality Framework for Long-Term Care Services (European Partnership for the Wellbeing and Dignity of Older People, 2012) had not been previously operationalised into validated measurable items or interview questions. We argued that in order to capture possible complexities and subtleties linked to the topic of quality of the long-term care provision, a qualitative case study design (Denzin & Lincoln, 2011) with semi-structured interviews would be most appropriate within our study. Using semi-structured interviews allowed for a reasonable degree of comparison between the two different long-term care systems for older people in the two countries that were being evaluated (Jongen, Burazeri et al., 2015), while simultaneously granting a certain degree of flexibility to continuously adjust and optimise the process of data collection (Boeije, 2005). The latter is important as the subject matter and our relationship to it is an evolving process (Neuman, 2014, p. 218). We developed interview questions that were constructed around the three selected quality principles of the European Quality Framework for Long-Term Care Services

Table 1.
The three selected quality principles of the European Quality Framework for Long-Term Care Services (European Partnership for the Wellbeing and Dignity of Older People, 2012).

Quality principle	Explanation
Person-centredness	A care recipient's unique character, interests, life history, social and health needs, intellectual and physical capacities, family circumstances and preferences should form the basis for the provided care. Long-term care services should furthermore be driven by the needs of caregivers and family members of older people when necessary and appropriate. Healthcare staff should be provided with the necessary support, resources and facilities to provide person-centred care.
Availability	A long-term care service should have the professional capacity and geographical coverage to improve the health, wellbeing and independence of everyone in need of long-term care and assistance. Long waiting lists should be non-existent when the principle of availability is adhered to. Availability also encompasses the freedom to choose between different care provision options, regardless of the personal care needs, situation or place of residence of the beneficiary.
Affordability	Having access to essential long-term care services should not depend on one's financial means. Long-term care services for older people should be provided either free of charge, or at a price which is affordable to the care recipient without compromising on quality of life, dignity and freedom of choice (endorsing the concept of universal access). Furthermore, financial support provided by collective social protection systems or in-kind support should be available so people can receive the long-term care they need without disproportionately impoverishing themselves or their families.

(European Partnership for the Wellbeing and Dignity of Older People, 2012), and aimed to operationalise each quality principle through three interview questions that collectively accurately captured that quality principle's essence. Additionally we incorporated one more question covering the thoughts and suggestions of our participants on how to further improve the quality of the long-term care provision in their country. The interview questions were then translated into Dutch and pretested individually with two independent healthcare professionals from academic backgrounds to safeguard validity. Application of a back-translation procedure of the interview questions was considered to be superfluous, due to the rather flexible nature of the interview process, with the interview questions serving primarily as a guideline (Jongen, Burazeri et al., 2015). The interviews were recorded on audio to facilitate processing of the data later on. Table 2 provides an overview of the interview questions that were used to guide the semi-structured interviews within our study.

Study population and sampling

The semi-structured interviews were conducted with experts in the field of long-term care. We defined experts as professionals who through study and/or experience had obtained profound knowledge and insights in a particular topic or field. More specifically, we aimed to identify experts in Belgium and the Netherlands who were able to provide comprehensive insights on how the recent changes in long-term care policy had affected large groups of dependent older people – and to a certain extent their families and their caregivers – in everyday practice. As such, we opted for applying a theoretical sampling technique to get cases that would help reveal features that were theoretically important for the specific setting and topic of our study (Neuman, 2014). Potential experts were identified and contacted by utilising the professional network of AGE Platform Europe. Additionally, in both Belgium and the Netherlands multiple (academic) research institutes, organisations providing long-term care for older people and advocacy organisations representing the interests and wellbeing of older people on a national or regional level were approached. In total, 14 Dutch and 25 Belgian organisations and individual experts were contacted, resulting in 5 Dutch experts and 4 Belgian experts participating in our study. Noteworthy is the fact that especially in Belgium, several organisations and experts declined to participate in the study by arguing that due to the recentness, magnitude and nature of the reforms, they had lost sight on the contemporary quality of the long-term care provision and were thus not able to elaborate on it. Paradoxically, this further emphasised the importance of the current study. Awareness of the geographic coverage of the sample of participants was considered to be important, as inherent to the decentralisation process of long-term care responsibilities in both countries, there could be relevant differences in long-term care quality on a local or regional level. In the Netherlands we included participants from multiple provinces and municipalities, and the experts indicated that they were able to elaborate on the quality of the long-term care provision on a national level. In Belgium, we merely included participants from the region of Flanders. We deliberately chose not to include the other regions of Belgium, as long-term care competences predominantly lie with the regional authorities, and Wallonia and Flanders can be seen as distinctly different in terms of long-term care policy. It might therefore be better to assess long-term care quality for the Belgian regions separately, instead of aiming to assess the quality of the long-term care provision for the federal state of Belgium as a whole. When interpreting the results of the current study, one must therefore be aware that findings for Belgium mainly apply to the region of Flanders, while the insights obtained for the Netherlands can generally be applied on a national level.

Several of the experts participating in our study were involved in the field of long-term care on multiple levels, meaning they fulfilled multiple professional roles at multiple organisations or institutions. Table 3 provides a simplified overview of the professional backgrounds of the participants of our study.

Amongst the interviewed experts were 2 Dutch and 2 Belgian directors of long-term care organisations. The two Belgian long-term care organisations were specialised in extramural nursing and personal care, with each organisation covering one of the 5 provinces of Flanders. The two Dutch long-term care organisations both provided a broad range of intramural and extramural long-term care amenities on a

Table 2.
Quality of the long-term care provision: interview questions.

Quality principle	Corresponding interview question(s)
Person-centredness	- To what extent are long-term care services tailored to the unique personal situation of older people? - To what extent are the needs and capacities of formal caregivers, informal caregivers and family members respected? - Does the way long-term care is currently financed contribute to a person-tailored care delivery?
Availability	- How does the way long-term care is financed influence the availability of care services for older people? - Are both medical long-term care and personal long-term care available to everyone in need of these types of care? - Do people have sufficient freedom of choice between different care providers, regardless of their care demands or place of residence?
Affordability	- What role do individual financial contributions play within the long-term care provision? - Are the individual financial contributions for obtaining long-term care affordable for everyone in need of this care, without compromises to quality of life, freedom of choice and human dignity? - Are people able to receive the long-term care they need without disproportionately impoverishing themselves or their families?
Suggestions on how to improve the quality of the long-term care provision	What changes are needed to improve the quality of the long-term care provision according to you?

Table 3.
The professional profiles of the experts who participated in our study.

Country	Participant identifier	Professor/academic researcher in long–term care or a closely related field	Representative of an advocacy organisation concerned with the (health–related) interests and wellbeing of older people	Director of an organisation providing long–term care for older people
The Netherlands	1	v		v
	2	v	v	
	3	v		v
	4		v	
	5		v	
Belgium	6		v	
	7			v
	8	v	v	
	9			v

municipal level. The advocacy organisations in the Netherlands included in the study were a national knowledge and expertise institute on long-term care, an advocacy group for informal caregivers and a national patient federation. One of the Belgian advocacy organisations included was a federation that represents nursing and retirement homes, local and regional service providers and day care centres in the long-term care sector. The other Belgian respondent linked to an advocacy organisation was amongst other things a taskforce member on long-term care for an international non-profit organisation concerned with the wellbeing of elderly.

Although ideally one conducts interviews and gathers data until a level of empirical saturation is reached, in practice this is not always possible or practical. Furthermore, even with a small sample one can produce a study with depth and significance (Baker & Edwards, 2012). We argued that by including a small, heterogeneous collective of knowledgeable experts on the topic of long-term care for older people, the contemporary quality of the long-term care provision in the Belgian region of Flanders and the Netherlands could be explored from multiple angles and in a heuristic manner, generating valuable insights and enabling a process of lesson-drawing on a European level.

To ensure confidentiality, all participants were asked to sign an informed consent form. Due to the theoretical sampling technique used and the interview procedure requiring actual face-to-face contact between the researcher and the interviewees, anonymity could only be guaranteed to the extent that names of persons and organisations were omitted upon publication of this article.

Data analysis

The audio files from the interviews were analysed through the application of directed content analysis (Hsieh & Shannon, 2005). The directed approach to content analysis works with prior formulated, theoretical derived aspects of analysis (Hsieh & Shannon, 2005; Mayring, 2000). This results in this form of content analysis being rather deductive in nature (Mayring, 2000). We opted for using the directed approach to content analysis as it enabled us to adhere to our conceptual framework of quality in long-term care (European Partnership for the Wellbeing and Dignity of Older People, 2012) when interpreting and categorising the research data (Hsieh & Shannon, 2005; Mayring, 2000). The three selected quality principles of the European Quality Framework for Long-Term Care Services (European Partnership for the Wellbeing and Dignity of Older People, 2012) were used as initial coding categories (Potter & Levine-Donnerstein, 1999). Using these predetermined coding categories, relevant findings from the audio-recordings were transcribed and categorised. Relevant data that could not be coded immediately were identified and analysed to determine if they represented a new category or a subcategory of an existing code (Hsieh & Shannon, 2005).

Results

In the following subsections, the results of our study will be presented in the same order as the different quality principles were previously introduced in Table 1. The different subcategories per quality principle were formulated based on the interview findings. The direct respondents' quotes are the authors' own translations from Dutch to English.

Person-centredness

Assessing and meeting an older person's long-term care needs

In theory, the long-term care benefit entitlements older people receive in Belgium and the Netherlands are need-based.

Still, both the Dutch and Belgian respondents argue that the long-term care provision is mainly supply-steered rather than demand-steered. Often the care one receives and the setting in which this care is provided are not guided by an individual's preferences and care needs, but rather by financial restrictions. In both countries, when an older person requests a form of long-term care, his or her care needs are assessed and categorised in accordance with predefined categories of a care severity classification system; each category corresponds to a different level of care and reimbursement. Still, this does not guarantee that people actually receive the care they need or the care they are entitled to. Due to budgetary constraints, the Flemish government has stopped acknowledging the highest intramural care severity category, as this category is linked to the highest rate of reimbursement. Older people meeting the criteria for this category – meaning they have severe functional limitations and high care demands – are now categorised as if they had lower care demands, which also results in a lower financial benefit entitlement. Consequently, long-term care providers are struggling to meet the high long-term care demands of this group with the limited financial means that are made available by the government for this purpose. In the Netherlands, similar discrepancies between the assessed care needs and the care that is actually provided can be observed in extramural settings.

Furthermore, according to the respondents, the Flemish and Dutch governments merely look at the level of disability when assessing a person's long-term care needs. There is insufficient attention for various factors that could contribute to a more person-centred care delivery, such as an individual's unique preferences, background and interests. In practice, it is up to long-term care professionals and social networks to give substance to a person-centred care delivery. Multiple Dutch respondents argue that despite budgetary constraints, it is still possible in this day and era to provide long-term care that is largely tailored to the individual needs of a recipient, although it does require a certain degree of flexibility and creativity from long-term care service providers and – in the case of the Netherlands – municipalities.

The needs of family members and caregivers

The quality principle person-centredness encompasses that long-term care services should also be driven by the needs of relatives and caregivers of older people when necessary and appropriate. In both countries, the strain on formal caregivers has been steadily increasing since the onset of the economic crisis. Especially in Belgium, some respondents expressed profound concerns about the working conditions of formal caregivers in the long-term care sector, as working in this sector is seen as both emotionally and physically burdensome. Night shifts are common practice for many long-term care professionals. Furthermore, the long-term care demands in both intramural and extramural settings have been steadily increasing over the last couple of years. As there generally is no budget available to hire additional staff, many long-term care professionals are confronted with a steadily increasing workload. This is furthermore aggravated by the aforementioned fact of the Flemish government not acknowledging the highest care severity category any longer; the budget that is made available for the most frail and dependent older citizens is not aligned with the actual care demands of this group. One Belgian respondent stated that formal caregivers should be allowed more flexible working conditions and an alleviated workload, as this respondent fears that many formal caregivers will not be able to work until retirement age under the current conditions.

The contributions of informal caregivers are seen by the respondents as indispensable to ensure the sustainability of the long-term care provision in both Belgium and the Netherlands, but at the same time informal caregivers face numerous difficulties. They are at risk of becoming socially isolated, and many of them experience a deterioration of their own physical and mental health when structurally providing informal care. Furthermore, many informal caregivers risk losing part of their income and pension rights when their informal care responsibilities force them to give up working hours. The respondents feel there is a lack of social support and financial protection for informal caregivers in both Belgium and the Netherlands.

Funding schemes and person-centredness

In the Netherlands, people who are entitled to receive long-term care can choose to receive a personal budget instead of in-kind benefits. Generally, this is seen by the Dutch respondents as a phenomenon that contributes to a person-centred care delivery, as it provides people a degree of freedom and autonomy in purchasing the care services of their preference. The Flemish government is currently pursuing a financing system quite similar to that of the Netherlands, in which care recipients receive a personal budget and become responsible for managing their own long-term care expenses. This Belgian system of “person-tailored financing” is expected to be introduced in 2018.

Availability

Intramural long-term care capacity

In both Belgium and the Netherlands one can observe a shift away from institutional long-term care towards long-term care delivery in people's own homes; a phenomenon referred to as “ageing in place”. However, this shift seems to be far more rigorous in the Netherlands. While the Flemish government does stimulate ageing in place and is increasingly relying on informal caregivers and local networks to meet the population's care demands extramurally, it still invests in additional intramural care capacity due to the sheer (anticipated) growth of the number of frail older citizens. Multiple respondents reported that between 2015 and 2018, the Flemish government aims at realising approximately 8400 new intramural residential units in addition to the 75,000 existing ones. In contrast, as part of the recent reforms in the Netherlands, the Dutch government has started rigorously decreasing the intramural long-term care capacity; the amount of beds in nursing homes and care homes is being reduced from approximately 165,000 in the year 2015 to 100,000 in the year 2017. When interpreting the aforementioned data it is furthermore important to note that the Flanders region has approximately 7.6 million inhabitants, whereas the Netherlands has approximately 16.9 million inhabitants. While in previous years older people with light to moderate functional limitations and care demands in the Netherlands were eligible to reside in care homes and/or nursing homes if they so desired – often also for social reasons, e.g. to counter social isolation and loneliness, or for the sense of security from having healthcare personnel around – within the

new long-term care system in the Netherlands, residential long-term care is reserved solely for those with the most severe functional limitations and the highest care demands. Essentially one could state that care homes and other living arrangements for older people with mild to moderate limitations (such as service flats) are completely disappearing, while only nursing homes remain. In Flanders, older people still have a greater variety of living arrangements available to them (e.g. nursing homes, care homes, service flats, assisted living facilities), and the government tries to keep up with the demands by investing in real estate.

Local initiatives

In the Netherlands, local initiatives such as "care cooperatives" and "city villages" are gradually emerging to complement the efforts of municipalities in the field of long-term care. Care cooperatives are collectives of older people and care professionals, who make their own arrangements with regard to living, wellbeing and care. The recent reforms have introduced a regulatory framework which allows these care cooperatives to officially take over certain long-term care responsibilities from the municipalities and to receive funding from the government for this purpose. In addition to care cooperatives, there is also an increase in the number of city villages. City villages are social networks within a small community – often confined to a certain quarter within a bigger city – which actively try to provide support, stimulate cohesion and mobilise volunteers to meet certain social (care) needs of the frail older people in the respective area. As both city villages and care cooperatives in the Netherlands operate locally, and both phenomena are rather new, the geographical coverage of these initiatives is still limited, although rapidly expanding. Similar initiatives were not mentioned by the Belgian respondents, although they did indicate that there is a diverse array of care services and social services available to older people which are provided by the government and long-term care organisations. Still, in both countries multiple respondents expressed particular concerns about the availability of adequate care and support for people from lower socio-economic backgrounds, who often lack the assertiveness and the connections to mobilise the care they need within their social network. The respondents argue it might also be more difficult to effectuate initiatives such as city villages and care cooperatives in disadvantaged neighbourhoods and in communities where social cohesion is lacking.

Freedom of choice

The Dutch respondents were remarkably united in their claim that the importance of freedom of choice is generally overrated in the long-term care provision, and that for most older people in need of long-term care and assistance, the freedom to choose between different care providers is not so important. One respondent emphasised that older people generally do not have the tools and insights to make an informed choice between different care providers. Furthermore, this respondent stated that "the healthcare system is not a market, and the patient is not a customer". Older people want to receive effective care and want to be treated with respect, and they generally do not mind which care provider facilitates in these needs.

For intramural long-term care, freedom of choice is seen as nearly non-existent in the Netherlands. Once a care recipient reaches a level of care dependency that justifies and allows institutionalisation, his or her care demands have usually grown so high that the urgency of being admitted in any intramural care facility that has a bed available generally prevails over the principle of freedom of choice. Furthermore, in both Belgium and the Netherlands, older people with severe psychogeriatric morbidity – e.g. Korsakoff's syndrome or certain types of dementia – can only be admitted in a very limited number of long-term care facilities which are specialised in dealing with the specific needs of this group. Freedom of choice often does not play a role in these cases as the urgent needs of a recipient dominate the principle of freedom of choice. For extramural nursing care, older people in Belgium can usually choose between various care organisations, while in the Netherlands the choice is often limited to the local nursing team that has been assigned by one's health insurer.

Waiting lists for long-term care

For Belgium some respondents indicated there are generally waiting lists for residential long-term care and medical procedures in the hospital. In the Netherlands, the possibility to receive a personal budget instead of in-kind benefits has proven to be very efficient to reduce the waiting lists for intramural long-term care, as many people opt to receive care at home when given the choice. The Dutch respondents do fear that population ageing in combination with the sharp reduction of intramural care capacity will lead to increasing waiting lists for institutional long-term care in the coming years. Currently the waiting lists for institutional care in the Netherlands are very short, but the respondents argue that this is partly due to the very strict eligibility criteria. The current situation in the Netherlands seems to be that there is a group of older people who would benefit from institutionalisation – as their care demands are not adequately met in their home setting – but who simultaneously do not meet the government's criteria to be admitted in a nursing home. While officially these people are not on a waiting list, some respondents argue that they should be.

Affordability

Affordability of institutional long-term care

Multiple Belgian respondents mentioned that within nursing homes, the costs of board and lodging – i.e. the costs of meals and accommodation – have increased by 20% over the past five years. Currently, the average price to reside in a nursing home is around 1500 euro per month, and this price is expected to further increase to 1800 euro per month within the next couple of years. As an average pension equals around 1200 euro per month in Flanders, this steep increase in residential lodging costs is seen as problematic by the respondents. Although the Flemish government does provide financial support in the form of housing subsidies, the respondents state that these subsidies are not sufficient for many people to meet their lodging expenses. Consequently, older people often have to use their savings, sell their house or depend on financial support from their children when they are institutionalised. In addition to the costs of board and lodging, there are the costs of healthcare staff, medication and medical equipment. As

mentioned in one of the preceding subsections, older people in Belgium who need long-term care are assessed and categorised using a care severity classification system. Based on the assigned care severity category, a predetermined budget is made available by the government to meet the care needs of a recipient. One respondent stated that this budget usually covers the most basic care proceedings and personnel costs. Long-term care organisations are free to hire additional staff and to intensify the level of care provided, but any supplementary costs that exceed the government's budget have to be covered by the organisation. In practice these costs are charged directly to the residents. As stated before, since a couple of years the Flemish government has stopped acknowledging the highest intramural care severity category, as this category is linked to the highest rate of reimbursement. Essentially this means that the government has substantially reduced the available budget for the most fragile and dependent older citizens, forcing long-term care organisations to either provide the necessary care without adequate reimbursement or to demand greater financial contributions from care recipients.

The Dutch government requires co-payments to cover the costs of care, board and lodging when people are institutionalised. The government takes into account both one's income and one's assets to determine the height of these co-payments. If someone has substantial assets and a relatively low income, then the government will require that one's assets are partly used to cover the co-payments. Still, the current system in the Netherlands does protect older people from losing their house or from running into problems with paying off their mortgage. Multiple Dutch respondents feel that the required co-payments are fair and reasonable, and that not all long-term care services should be financed collectively. These respondents state that just because someone reaches a certain age and develops a certain care need, this should not necessarily imply that suddenly all his or her needs have to be met and paid for by society.

Affordability of extramural long-term care

In both the Netherlands and Belgium, extramural nursing care is completely covered by social insurance, and no co-payments are required. This does not apply to personal care and domestic assistance, for which in both countries co-payments are required. In Belgium, the rates of personal care and domestic assistance are fixed by the government. Older people in Belgium can purchase service vouchers with which they can obtain assistance with instrumental daily living activities (e.g. ironing, grocery shopping) and special transportation services in case of mobility problems. These service vouchers are heavily subsidised by the government and exempted from tax, resulting in older people effectively paying a fee of around six euro per hour of service obtained.

Since the recent reforms in the Netherlands one's financial means and social network play a more significant role in obtaining social support and personal care services, and the respondents report that especially for the group of older people who are unable to mobilise their social network, affordability is becoming an issue. Due to budgetary constraints, many municipalities in the Netherlands are unable to meet all the social and personal care needs of older people. Consequently, the Dutch respondents have noticed a vast increase in the number of for-profit organisations trying to fill this apparent gap in the market. The services provided by these organisations include paid companionship, assistance with household chores and other personal care tasks. Many of these services are however seen as too expensive for older people with a low socioeconomic status, while this group would arguably benefit most from obtaining these services.

Suggestions for improving the quality of the long-term care provision

The participants of our study provided various suggestions on how to further improve the quality of the long-term care provision in their country. While some of these recommendations have already been partly covered in the preceding subsections, a comprehensive summary of all relevant recommendations for both Belgium and the Netherlands can be found in Table 4. We included suggestions that were supported by multiple respondents, as well as suggestions that were merely mentioned by a single respondent.

Discussion

By utilising the expertise and insights of multiple experts involved in the field of long-term care, the current study has put forward an overview of the contemporary quality of the long-term care provisions for older people in the Netherlands and the Belgian region of Flanders following recent policy reforms. In this final section, we will summarise the principal findings of the current study and move towards their broader implications.

Principal findings

After analysing and categorising the data, some noteworthy similarities between Belgium and the Netherlands were uncovered, as well as some distinct differences. In both countries it seems that certain vulnerable groups of older people – particularly those from lower socio-economic backgrounds – face increasing difficulties regarding the affordability of long-term care services. In the Netherlands concerns regarding affordability seem most pronounced for personal long-term care in extramural settings, while in Belgium issues with affordability are most visible in intramural settings, due to the continuously increasing costs of institutionalisation. In both countries, accessibility and availability of long-term care services are seen as potentially problematic for older people who lack a supportive social network, and in the Netherlands it furthermore seems to vary widely between municipalities whether certain care services are available and accessible. Although respondents in both countries state that the long-term care provisions in their country are predominantly supply-steered rather than demand-steered, the Dutch regulatory framework currently seems to be more flexible than its Flemish counterpart for allowing a person-centred and comprehensive long-term care delivery. In both countries there are concerns about the increasing strain on caregivers, although in the Netherlands these concerns seem more pronounced for informal caregivers, whereas in Belgium these concerns are more pronounced for formal caregivers. One of the more striking differences between the two countries relates to the availability of residential units in nursing homes and care homes; while the Flemish government invests in additional intramural residential units, the Dutch

Table 4.
Summary of recommendations on how to improve the quality of the long-term care provision.

Country	Suggestions on how to improve the quality of the long-term care provision
The Netherlands	**- A greater emphasis on healthy ageing and initiatives with a preventive focus – supported by technological innovations and home adaptations – is recommended. Housing corporations should carry an increased responsibility in the realisation of a sufficient supply of suitable housing arrangements, i.e. houses with special adaptations to support older persons' capacities to live independently. Technological innovations could furthermore contribute to a decreasing necessity of caregivers having to physically attend to a care recipient's needs.** **- The national government, the municipalities and the health insurers should increase their collective efforts in supporting informal caregivers and equipping social networks and local communities for adequately addressing the care needs of dependent older people.** **- Long-term care organisations and municipalities have to be creative and flexible in meeting their responsibilities in the field of long-term care. Municipalities and long-term care organisations should actively explore and adopt good practice approaches for dealing with the recent changes in the long-term care sector**. - As the emphasis on self-care is increasing, municipalities should launch initiatives to improve older persons' self-management skills, health literacy and computer literacy. - The priority of healthcare professionals in the extramural long-term care sector should be to support, coach and coordinate volunteers and informal caregivers on a local level. Informal caregivers should be trained, instructed and supervised by professionals as their responsibilities in the care provision are increasing. The government should set up the required infrastructure for this process. - Currently there are no quality requirements for informal caregivers, even though many of them are paid for their contributions with public means (through a beneficiary's personal budget which is paid for by the government). Therefore, the government should consider introducing a qualification and certification system for informal caregivers, to ensure certain quality standards are met when pubic money is spent on care. - The generation of young and active senior citizens (aged 60–70) should be mobilised to support their old and frail neighbours. Together with municipalities these young senior citizens have a key role to play in setting up initiatives like city villages (a good practice example here being the city of Amsterdam, where so far 22 city villages have been founded). - The expediency within long-term care organisations should be increased by getting rid of unnecessary bureaucratic administrative proceedings. All steps within the care process should have a proven added value and should contribute to a better care delivery.
Belgium	**- The federal and regional governments should revamp and simplify the regulatory framework in the field of long-term care to allow for a more flexible service delivery with less bureaucratic bottlenecks interfering with the care delivery process.** **- There should be more collaboration and dialogue between the federal and regional governments and the various actors in the field of long-term care. The Belgian respondents feel the long-term care sector would benefit from more collaboration in assessing the exact care needs of each individual care recipient and for consequently developing a treatment plan that is supported by all relevant actors**. **- Adherence to a financing system in which the allocation of financial resources and staffing corresponds to the actual care needs of the care recipients in a uniform and non-arbitrary manner, without differentiating between different age groups**. - The regional governments in Belgium should facilitate the transition of the long-term care system by actively supporting the development of digital healthcare platforms. Concretely, an expansion of functionalities of the already existing Flemish and national e-health platforms is suggested. - The federal and regional governments should invest in supplementary arrangement to reduce the strain on informal caregivers. More concretely, the government should invest in psychosocial support for informal caregivers, possibly through dedicated social support networks. Informal caregivers should also be better protected from losing their pension rights and social benefits when having to care for a dependent family member or loved one. - An increased focus on prevention of morbidity in old age, by stimulating active ageing and age-friendly environments. Specific areas that require more attention are healthy nutrition, physical activity and self-care activities. - The financing mechanisms behind long-term care should be reorganised in a way that supports investments in innovative solutions. - The government should develop a system to monitor the safety of patients within the long-term care sector, as one correspondent feels there are currently too many incidents jeopardising older people's health. This monitoring system should cover both institutional care settings and extramural care settings.

Note: Suggestions that were supported by at least two respondents are written in boldface.

government is reducing the intramural long-term care capacity by approximately 40% within a two year timespan.

The Dutch respondents all emphasised the value and necessity of decentralising responsibilities in the long-term care sector and reducing public expenditures on long-term care. They argued that organising and providing care on a local level with support of volunteers, social networks and informal caregivers is the only suitable solution to ensure the sustainability of the long-term care provision. The Dutch government is however criticised by the participants for the rigorous manner and fast pace with which the recent reforms have been implemented. The Dutch respondents feel that the rate at which the intramural long-term care capacity is being reduced, greatly exceeds the rate at which new local social structures are being created and strengthened. Consequently, many municipalities, social networks and informal caregivers are ill-equipped to meet their increased responsibilities in the field of long-term care. In contrast, the long-term care provision in Belgium seems to be undergoing a more incremental transition, with various competences being transferred from the federal to the regional level over a timespan of multiple years. Furthermore, the budget cuts accompanying the transition of the long-term care system in Belgium seem to have been less rigorous and precipitous than the budget cuts that have accompanied the Dutch long-term care reform.

Both the Belgian and Dutch experts evaluate their government's idealistic and ideological reasoning behind the reforms – to ensure tailor-made care, delivered closer to home, with the support of a caring and involved society – as being mainly rhetoric, with the real driving force behind the reforms being the need for austerity measures. Schröder-Bäck, Stjernberg, and Borg (2013) state that in the wake of the Eurozone public debt crisis, cutbacks on healthcare expenditure and social welfare benefits are often seen by decision makers as a short-term solution to alleviate budgetary pressure. This in turn is viewed by others to be a breach of

the European Union's overarching health-related values of solidarity, universality, equity and access to good quality care. Schröder-Bäck et al. argue that although these values offer us some degree of orientation, in times of tough decision making they might not provide the concrete guidance we seek as a society. Instead, the 'accountability for reasonableness' approach of procedural justice by Daniels and Sabin (2008) is proposed to be taken into consideration when making decisions on health and healthcare policy in times of economic turmoil. This approach offers a minimal ethical standard when a scarcity of resources leads to an inability to satisfy all needs that might exist in a society. Daniels and Sabin emphasise that a fair and deliberative process should proceed complex resource allocation decisions. This encompasses that any decisions that are made, as well as the reasoning behind these decisions, have to be completely transparent to the public. Furthermore, the reasons by which decisions are made have to be relevant and agreed on by all relevant stakeholders involved. Decisions should be subjectable to revision if new valid arguments are introduced, and one must refrain from discrimination and stigmatisation. Using this accountability for reasonableness perspective to evaluate the recent long-term care reforms in Belgium and the Netherlands, it seems there is ample room for improvement. In both Belgium and the Netherlands it seems that consensus amongst relevant stakeholders for the chosen course of action within the long-term care sector is largely missing, as informal caregivers, long-term care organisations and municipalities have proclaimed to experience substantial difficulties to cope with the reforms. Under the premise of a more qualitative, person-centred care delivery, the consequences of the reforms have been predominantly negative when looking at the availability, person-centredness and affordability of long-term care. Still, some promising initiatives are gradually emerging (e.g. city villages in the Netherlands), and in due time these initiatives could help ameliorate the quality of the care provision, although the geographic coverage and social reach of these initiatives still have to increase vastly. Investing in these initiatives might seem counterintuitive to policy makers in times of economic crisis, but relatively modest investments in these initiatives could alleviate budgetary pressure on the long term, as they facilitate the transition of long-term care responsibilities from the formal to the informal care sector. In Belgium the main difficulties jeopardising quality of care are the high housing costs in intramural settings and the decreasing budgets allocated to the care of the most frail senior citizens. Small improvements in Belgium might be underway, such as the person-tailored financing system which is scheduled to be introduced as part of the ongoing reforms.

Broader implications and conclusions

While the primary aim of this study was to evaluate the quality of the long-term care provision in Belgium and the Netherlands, we argue that the obtained insights transcend the borders of the countries under evaluation. Many countries are currently confronted with similar predicaments on how to reorganise their long-term care systems in a sustainable manner. Analysing the contemporary situation in Belgium and the Netherlands and critically evaluating the approaches chosen by the Belgian and Dutch governments allows for a process of lesson-drawing on an international level. Ensuring that the various quality principles are met within the long-term care provision seems to depend on a dynamic interplay between different actors; while national and regional governments set the stage through the regulatory frameworks and financing mechanisms they introduce, it is subsequently up to long-term care organisations, local social networks, formal and informal caregivers, municipalities and health insurers to give substance to a high quality long-term care provision.

We conclude by arguing that new and creative approaches to long-term care are needed to meet the increasing care demands of older people throughout Europe. This implies that regulatory frameworks should provide the necessary flexibility to explore new initiatives within the long-term care provision. Furthermore, when confronted with demographic changes of this magnitude, it is important to ensure that older people remain healthy and independent as long as possible. This requires a holistic approach, with additional investments in age-friendly environments, technological innovations and home adaptations, and greater emphasis on healthy nutrition, physical activity and self-care activities amongst the elderly. Also, it seems that throughout Europe, informal caregivers have an increasingly important role to play in meeting the care demands of dependent senior citizens (Naiditch, Triantafillou, Di Santo, Carretero, & Hirsch Durrett, 2013). This underlines the importance of supportive measures to improve the quality of the care provided by informal caregivers, but also to ensure their wellbeing. The collective efforts of informal caregivers can substantially alleviate the strain on the formal care sector and contribute to a sustainable long-term care delivery, but at the same time it is clear that an increased reliance on informal caregivers can be highly problematic. Providing informal care frequently takes a heavy toll on a caregiver's mental and physical health; many informal caregivers are structurally overburdened and are furthermore at risk of suffering severe adverse social and financial consequences. Therefore, governmental support measures for informal caregivers should include both practical support, such as the facilitation of home modifications for people who want to provide informal care to their relatives at home, as well as preventive support, such as special education for informal caregivers (Jongen, Commers, Schols, & Brand, 2015). In line with the findings of Nies, Leichsenring, and Mak (2013), we argue that these support measures have to be tailored to the individual needs and expectations of informal caregivers, while simultaneously taking into account the divergent cultural, social and religious values across Europe which guide and influence public opinion on who should take on certain care responsibilities and what form this care should take. Regarding informal care and improving the financial viability and sustainability of the long-term care provision, we also argue that the generation of active and healthy senior citizens should be mobilised to provide structural supplementary peer support for the frailer members of their communities. Other countries, like Japan, already have broad experience in implementing similar "mobilisation strategies" on a larger scale (Hayashi, 2015), offering valuable insights and lessons for the Dutch and Flemish governments.

Study limitations and suggestions for further research

In both countries, the long-term care reforms that created the premise for conducting the current study came into force

fairly recently. The current study offers a provisional exploration of how quality of care has been affected by the reforms. Still, several Belgian and Dutch respondents stated that it will take several years before one can accurately assess what the exact consequences of the recent policy reforms have been for the quality of the long-term care provision. As a suggestion for further research, we opt for continued evaluation of the quality of the long-term care provisions in both countries in years to come, while incorporating the same quality principles that were used in the current study.

The current explorative study can also be seen as a pilot-study for operationalising some of the quality principles of the European Quality Framework for Long-Term Care Services (European Partnership for the Wellbeing and Dignity of Older People, 2012) into interview questions. We encourage other researchers to further develop the proposed interview questions and to explore additional ways of operationalising the quality principles of the European Quality Framework for Long-Term Care Services (European Partnership for the Wellbeing and Dignity of Older People, 2012).

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