ESPN Thematic Report on Challenges in long-term care

Luxembourg

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Jozef Pacolet & Frederic De Wispelaere
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Contact: Giulia Pagliani

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

European Commission
B-1049 Brussels

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European Social Policy Network (ESPN)

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Summary

Luxembourg was one of the pioneering countries in Europe to install an explicit pillar of long-term care (LTC) insurance. It was created from 1999 on and was adapted in 2005 and then in 2017. The new system has applied since 1 January 2018, but the major principles from the very beginning have been maintained – giving priority to home care over residential care, and prioritising in-kind services over cash benefits.

The financing is guaranteed by a 1.4% contribution from workers, the self-employed and all others with income, and a contribution from the state budget of 40% of expenditure. Also the principle of multidisciplinary assessment of dependency has been maintained and is now integrated in the form of a new dependency scale of no fewer than 15 levels, plus an additional level 0 in the home care setting.

This pillar of social security is organised by the National Health Board (CNS), while a huge operational role is attributed to the CEO, the committee responsible for dependency assessment and for drawing up a care plan. Service providers are regulated by the Ministry of Family.

Total spending in 2016 was some EUR 576 million, 1.1% of GDP (or, perhaps more appropriately for a small country, some 1.6% of GNI). There were 13,742 beneficiaries: 4,560 in the residential setting and 9,182 in the home care setting.

The LTC insurance sought from the beginning to favour in-kind support over cash support, though at the outset it was perceived to be more oriented to cash support. Despite the fact that its cash benefit is only used in home care settings, it remains visible and is claimed by 79% of the beneficiaries of home care: some 16% take only cash benefits and 63% prefer a mixed scheme. In financial terms, cash benefits are however limited to 10% of total expenditure on LTC. Of the other LTC expenditure, some 67% goes on residential care and 33% on home care – exactly the reverse of the number of beneficiaries (33% in residential care and 67% in home care). The average cost per beneficiary in residential care is four times the average cost in home care, illustrating the difference in care needs between those two categories.

Although the number of beneficiaries is higher in the home care setting, more recently the number of persons in residential care has been increasing more rapidly, and this is projected to continue in the future at an accelerating rate. Although the LTC insurance for the elderly is defined at a high level of social protection, several indicators point to growing concern over efficiency and cost containment. Although budgetary and regulatory reforms handle this with care, there is growing concern among providers and trade unions about its adequacy. On top of the LTC benefits in kind and in cash, some minor instruments exist to support the informal main carer to combine care and work life. On the other hand, for informal carers who are not building further up pension rights in their professional activities, the LTC insurance guarantees continued payment of pension contributions, ensuring a better pension later. Since LTC insurance was introduced, some 3,000 people have benefited from the system. Also cash benefits support informal care and could stimulate withdrawal from the labour market (although for most users it supplements their income).

The benefits in kind for the home care settings cover total cost and do not require co-payments by users. This is not the case for residential care, where the user also has co-payment charges specifically to cover the housing and catering costs (*prix d'hébergement*). While total public financing for residential care is some EUR 204 per day per beneficiary, the *prix d'hébergement* is around EUR 81. Those whose income is too low can claim complementary reimbursement from the *Fond National de solidarité*. The latest year for which data are available some 15% of individuals applied for this assistance. While in relative terms (and in the international perspective) this co-payment is reasonable, it again makes home care more attractive. There is incidentally also a minimum threshold of 3.5 hours of care needed to be eligible for the residential care benefit. And so Luxembourg's LTC system remains home care oriented.

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

Compulsory long-term care insurance – so-called 'dependency insurance' – was passed by Parliament on 19 June 1998 and introduced in 1999 as a new risk or pillar of the social security system. It sought to bridge the growing benefit gap for long-term care services, which until then had been granted by health, work accident and invalidity insurances; otherwise people had to rely largely on their own resources to finance their needs for care at home or in an institution. To a large extent, they could now rely on the new system of public financing (CEPS, 2007). This was one of the first schemes in Europe for an explicit long-term care insurance (Pacolet et al., 2000a and 2000b).

Four principles were at the core of this law and remained guiding principles:

- Priority for rehabilitation measures over long-term care
- Priority for at-home care over institutional care
- Priority for in-kind services over cash benefits
- Continuity of long-term caregiving.

Affiliation to long-term care insurance is mandatory for salaried and self-employed workers and access to continuous insurance benefits is guaranteed from the first day of membership. For those without mandatory insurance, voluntary insurance is possible, for which a qualifying period of 1 year is applied. Contributions to the long-term care insurance have to be paid at a rate of 1.4% of all earnings (including fringe benefits and capital) without any upper threshold. This feature is unique in Europe (IGSS, 2013b: 177). It is a social security contribution to be paid by employees, the self-employed and other income earners.[1] This special contribution is supplemented by a state contribution of 40% of total expenditure (MSS, 2016). Finally, a symbolic contribution from the energy sector is required.

The law on LTC insurance dates from 1998 and was partly adapted in 2005 to reinforce the original principles mentioned above. It is seen as an important instrument for responding to the needs of an ageing society. But not only are the needs of older persons taken into account; so are the existing needs of handicapped persons. It finances the need for support at home or in a residential setting. The support is defined in terms of the number of hours of care and help needed. A sum to cover the number of hours required can be taken in cash and used to reimburse the main supplier of informal care. An informal carer is a person close to the dependent person (such as a member of the household, other family members and others) available to provide help and who is registered with the dependency assessment board (CEO – see below); he/she may be someone hired especially. His/her availability and training needs are also identified and assessed at the same time as dependency is assessed by the CEO, and a clear division between informal help and professional help is recorded in the individual care plan.

The National Health Board (CNS – *Caisse Nationale de la Santé*) is responsible for paying for the care provided, while a set of providers of both community care and residential care is identified and regulated. Four types of providers are identified: home care and home help providers; outpatient centres; institutions for temporary stays; and institutions for permanent stays. The first two are included in care at home; the latter two belong to the residential care sector. In a recent study by Eurofound (2017) on the ownership structure of residential care providers, no information was available for Luxembourg on the share of the for-profit sector, the private non-profit sector or the public sector. Based on the register provided by the Ministry of Family, public, private non-profit and commercial initiatives are all active in both the home care sector and the residential care sector (Ministère de la Famille, de l'integration et à la Grande Région, 2016). The dependent person is eligible for those benefits in kind. The providers are directly reimbursed by the CNS. People are only

[1] With an amount of EUR 441.85 per month on which contributions are levied.

entitled to residential care when their need for care exceeds 3.5 hours a week. When they choose home care, they can receive the benefit in cash or else as a combination of support in kind and cash. The help and care provided by informal care is defined in the care plan, and in case of a combination of cash and in-kind benefits, those activities are clearly distinguished.

The main providers of both home care and residential care offer help and personal care, but also nursing care and rehabilitation, as well as other prescribed medical care, such as physiotherapy. Some of those services are also included in the health insurance. The service providers of LTC are recognised and controlled by the Ministry of Family and Integration, and a register is published regularly (Ministère de la Famille, de l'integration et à la Grande Région, 2016).

A specific administration under the Ministry of Social Security, the *Cellule d'Evaluation et d'Orientation* (CEO) was created to evaluate requests from dependent persons. During the initial phase, efficient procedures for assessing the needs of applicants had to be developed. Other problems at this early stage included a lack of beds in care institutions and how to meet the need for technical adaptations in the homes of dependent persons.

A first modification of the law on LTC was carried out in 2005 and came into force 2 years later. This further specified and slightly amended the benefit package. The representative organisation of the care providers COPAS (*Confédération des Organismes Prestataires d'Aides et de Soins*) became the recognised negotiating party for the tariff agreements between the CNS and the service providers (COPAS, 2017c). Furthermore, the law established a Quality Commission and changes to the long-term care benefits were introduced. In the following years, the long-term care system evolved further and was the subject of political debate on multiple occasions.

A long-planned new reform was finally proposed by the government in June 2016 and passed on 12 July 2017. The reform aims to guarantee a better focus on individual needs, simplified procedures and institutions, and maintenance of the social ties of dependent persons (improved social integration). The reform came into effect on 1 January 2018.

Without changing the guiding principles or mechanisms of the LTC, several changes have been introduced to improve the patient-oriented character and transparency, and to simplify the administrative burden.

The dependent person is helped to remain integrated within his/her family thanks to increased attention paid to informal carers: their contribution is assessed at the start; and more respite care is provided, as is annual training and more regular follow-up. The last element goes hand in hand with the ambition to provide more frequent reassessment, which should guarantee a care plan that is better adapted to the evolving needs of the dependent person. For informal carers who are not building up future pension rights from other professional activities, the LTC insurance guarantees entitlement to a pension for the period they provide informal care. The LTC insurance pays the employers and employee contributions up to the level of the minimum wage for a qualified worker[2].

On the issue of transparency, a new and more detailed list of dependency and support categories will be defined and reported for each individual dependent person in a more transparent way. Certain categories of support are redefined, to make the ambition of integration within the home setting more visible. Flexibility is increased through the introduction of no fewer than 15 categories of dependency. The scope of services is enlarged, with more time for guidance and social integration, on top of personal care and housekeeping.

The evaluation and orientation division (CEO) within the General Social Security Inspectorate (IGSS – *Inspection générale de la sécurité sociale*) became an

[2] Those contributions are also paid up to the same minimum wage if the dependent person hires a professional carer instead of relying on an informal carer.

independent body – the dependence insurance evaluation and control authority (*Autorité d'évaluation et de contrôle des prestations de l'assurance dépendance*), comparable to the social security medical control body (*Contrôle medical de la sécurité sociale*). The authority is not only responsible for assessment of the care plan by multidisciplinary teams, but will also have to monitor a) the congruence of the care actually provided with the care plan and b) the quality of the care provided. x

The National Health Board (CNS) remains responsible for paying for the care provided, while the same set of providers remain in both community care and residential care. It is worth remarking that the control efforts of the CEO are more frequent for informal care settings (yearly), while the assessment of adequate care plans in the formal settings is left to the providers, and the CEO has to check up only every 2 years.

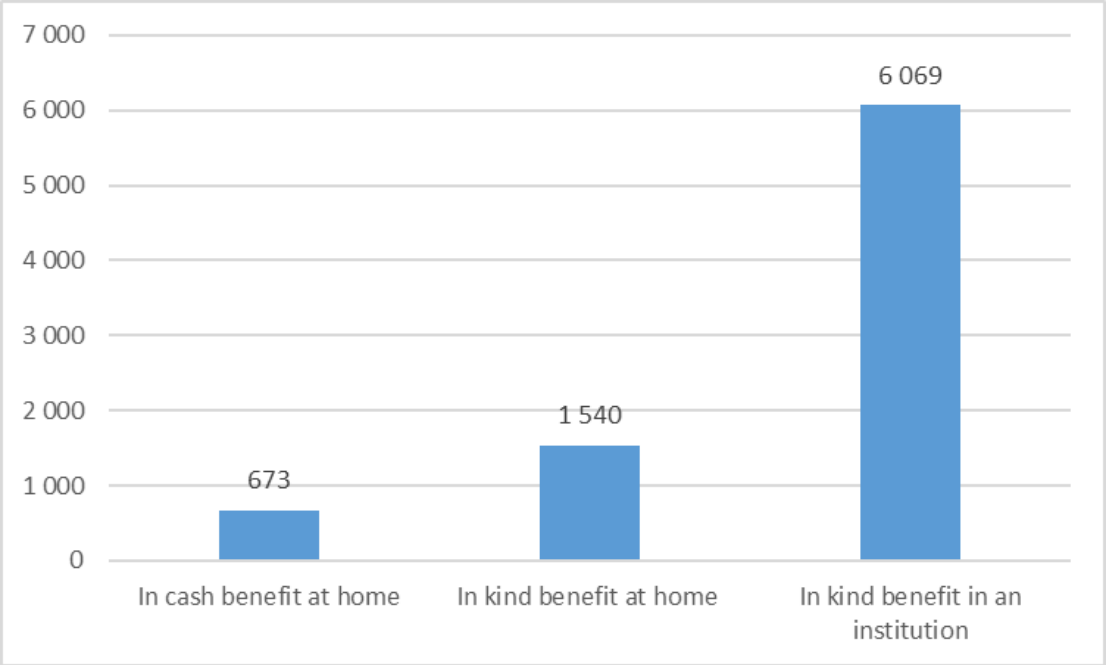
After a series of further consultations, the government decision to have the reform voted, seems to have allayed some concerns. The introduction of 15 levels of dependency is considered a reasonably flexible system, particularly since they are defined as a series of ranges spanning the minimum and the maximum number of hours required. The evaluation and control authority will also employ more staff to perform the checks.

In Appendix 4, we provide the 15 new dependency categories defined according to the number of minutes of support required of formal or informal help. In the residential care setting, 15 levels of compensation are defined, again in terms of the number of minutes per week. In the home care setting there is one additional category, level 0 – defined again in terms of the number of minutes per week to be covered by compensation. It implies that people are only eligible for LTC insurance in a residential setting from the moment they need more than 210 minutes per week (3.5 hours). At home, it can be below this threshold. In the home care setting, the benefit can also be received in cash. The dependency level is translated then into one of the 10 levels of cash benefits – a weekly sum of money that corresponds to the number of minutes of care provided by an informal carer. For instance, someone with a dependency need of 500 minutes will have dependency level 3 and will be entitled to benefit in kind of *forfait* (package) 3. If the person prefers to receive the benefit completely in cash, he/she will be entitled to *forfait* 9, worth EUR 212.50 per week.[3] If he/she needs only 100 minutes per week of informal care, he/she can receive the cash *forfait* 2. For any remaining need for professional home care he/she is entitled to the remaining time under in-kind home care *forfait* 2.

Figure 1 illustrates the differences in the unit cost per type of benefit, given in euro per month. Although widely used in home care, the cash benefit is low by comparison with the cost of professional care at home – and far lower than care in an institution. However, it is certainly not negligible: it is to be compared to the cash benefits in Flanders of EUR 130 per month for more dependent situations at home (and for everyone in an institution), or the income-tested care allowance for the elderly in Belgium of a maximum of EUR 571 per month (Pacolet and De Wispelaere, 2018). The cost per beneficiary in a residential care setting is four times the cost in the home care setting.

[3] It is worth remarking here that the highest level of compensation for informal carers is still toward the lower end of the dependency scale, illustrating that – despite the support for the informal carer – this is limited to compensation for the care time at the lower end or for a basic number of hours, leaving the more intensive care to the professionals. It confirms the original principle 'priority for in-kind services over cash benefits'.

Figure 1: Unit cost per month per beneficiary for in cash and in kind benefits, in EUR, 2015



Source: own calculations using Appendix 1.

In the past, the monetary value of the time compensated by LTC insurance was negotiated between the CNS and COPAS and was differentiated according to the different types of services. Since the reform, the monetary value is defined by the CNS, based on objective parameters, and differentiated between the residential setting and the home care situation.

On top of the traditional cash and in-kind benefits provided by LTC insurance, certain other instruments support the informal carer and help to combine working and caring for dependants. Measures to reconcile care and work – such as carer's leave – are average in terms of their generosity because of their limited scope and duration. Nonetheless, an important advantage of the carer's leave in Luxembourg (compared to other countries) is that the full wage is payable during the leave: the leave is considered in the same way as sick leave, and employers recover it from their employers' mutual insurance (Pacolet and De Wispelaere, 2016: 6).

An important support for the informal carer is the continuation of contributions to the pension of the main carer. This is an important instrument to support informal care by safeguarding the pension rights of informal carers, but it is only available to one person. In the period 1999-2016 some 3,429 persons benefited from this regime (IGSS, 2017: 119).

The LTC insurance provides cash and in-kind benefits. Despite the fact that two thirds of the claimants of LTC insurance are cared for at home, and although two thirds of them opt for a combination of professional and informal care, where the cash benefit could imply remuneration for the economic value of informal care, the overall importance is limited. Some 79% of the recipients of at-home long-term care also receive cash support, but the budget amounts to 10% of all public expenditure on long-term care and represents a unit cost of 10% (IGSS, 2013b: 169) of GDP per capita in 2016 (as can be seen in Appendix 1). Only 21% receive only in-kind benefits; 16% receive only cash benefits (in the early years of the newly introduced LTC insurance it was 49%!); while 63% prefer combined cash and in-kind support.

The system also results in a relatively low level of co-payment by users: there is no co-payment for in-kind services either at home or in an institution (except that in the latter case there is co-payment for the cost of accommodation). If an elderly person cannot afford this, the *Fonds National de solidarité (FNS)* can allow a supplementary *complément accueil gérontologigues* to balance the individual's contribution with his/her income. Pocket money of EUR 441.85 per month is safeguarded (Fonds national de solidarité (FNS)). In 2016, some 661 persons benefited from this, to a total amount of EUR 8 million (*Fonds National de solidarité,2016)*. The *complément accueil gérontologiques* depends on both the income and the financial and real-estate assets of the beneficiary. In Luxembourg, children are also obliged to bear their parents' costs, if necessary. The accommodation cost (*prix d'hébergement, prix de pension*) in one of the largest providers, Servior, for instance (which has 1,650 elderly people residing in its institutions – absorbing more than one third of the sector) starts at EUR 2,460 per month (or EUR 81 a day). The average financing from LTC insurance in 2016 was some EUR 204 per day per beneficiary.[4]

Although right from the outset until 2015 home care was prioritised, the most recent reforms have led to a rapid increase in residential care (see Appendix 3). In the evaluation report for 2013 (IGSS, 2013a: 321) this was projected from 2012 until 2030, with a yearly increase of 2.6% in residential care and 2% in home care. The more recent projections of IGSS used in the proposal for the 2016 revision hypothesise yearly growth from 2015 until 2045 of 3.1% for institutional care and 2.7% for home care. The increased growth rates are explained by the demographic impact of 'double ageing' (not only an increase in the number of people over 65, but also in the number over 85). According to this hypothesis, a contribution rate of 1.4% for LTC insurance and co-financing by the state of 40% will ensure financial equilibrium until 2035. This implies that until around 2027 there will even be an increased accumulation of reserves. From then on, reserves will be depleted to maintain the global financial equilibrium. From 2035, those reserves will be depleted completely and from then on there will be a cumulative deficit if financing is not increased.

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

Here we assess the major challenges that confront LTC in improving access to and the adequacy, quality and sustainability of the LTC system, and look at how present reforms are responding to those challenges. We offer some policy recommendations.

2.1 Challenges in LTC

Total expenditure rose from EUR 519.6 million in 2011 to EUR 575.6 million in 2016 (Le portail des statistiques). This nominal increase over 5 years was limited to 11% (see index 2016) – by chance, the same increase as in the total number of beneficiaries. But the latter is an increase in the real number of dependent persons. Inflation probably eroded the budget. We also see a shift from home care (which still remains dominant) to residential care. This shift is even more pronounced in the budget, since there is an increase in spending on residential care, but a decline in total spending on home care. The progressive view of prioritising home care over residential care is confronted with the fact that increasing care need and use in the residential setting risks crowding out home care unless additional funding is provided, also in the short term.

[4] Calculated for 2016 on the basis of table 1.

Table 1: Evolution of number of beneficiaries of LTC and spending, 2011-2016

	2011	2012	2013	2014	2015	2016	Index 2016 (2011=100)
Beneficiaries of long-term care, number of persons							
Residential	3 931	4 149	4 253	4 388	4 497	4 560	116
Home	8 457	8 857	9 125	9 102	9 045	9 182	109
Total	12 388	13 006	13 378	13 490	13 542	13 742	111
Expenditure on long-term care, in EUR million							
Residential	272.9	278.2	293.2	312.2	330.4	33f9.0	124
Home	232.0	195.0	211.8	195.1	227.3	223.0	96
Total	519.6	488.5	518.5	521.0	572.7	575.6	111
Total expenditure on LTC as % of GDP and GNI							
% of GDP	1.2	1.1	1.1	1.0	1.1	1.1	
% of GNI	1.7	1.6	1.7	1.6	1.7	1.6	

Source: Own calculations on figures for beneficiaries from IGSS and benefits from LTC insurance (in EUR millions) and Gross Domestic Product (GDP) and Gross National Income (GNI), Le portail des statistiques, Grand-Duché de Luxembourg, http://www.statistiques.public.lu/stat/TableViewer/tableView.aspx?ReportId=13002&IF_Language=eng&MainTheme=3&FldrName=2&RFPath=12686

In 2010 and 2011, there was a substantial deficit (Projects de loi, 2016), while between 2012 and 2015 there was a small surplus – or almost a balance between revenue and spending. Only in 2016 did the IGSS (2017: 132) report a substantial surplus. The report of IGSS even mentions a decline in total spending, not visible in the statistics of the Statistics Portal, so that the required reserve has evolved from 24-25% of total spending to 32% in 2016.

In Appendix 3 we present for 2015/2016 the total number of providers of long-term care services in Luxembourg and their personnel. There are in total some 171 providers, with a total of 9,427 persons (or 6,594 full-time equivalent (FTE) jobs). While the home care sector accounts for only 31% of the total number of personnel, it accounts for 40% of the budget and 67% of the number of users. While only 33% of users stay in residential care, it accounts for 60% of the budget and as much as 67% of the personnel. In the total home care budget, the budget for cash benefits is included. When corrected for this, the share of home care in the budget becomes 34% and for residential care 66%. This is almost exactly the reverse of the relative share of users, as mentioned above: 67% at home and 33% in a residential setting. It implies that the average cost of professional home care (without the cash allowance) is a quarter of the cost of professional care in an institution. Those macro-figures reflect the reality in the sector that home care services more than two thirds of the target group, with just one third of the budget and personnel resources. It also reflects the fact that entry to residential care is restricted to more dependent situations that require more intensive input of personnel.

Five years after the launch of the new system, a first assessment was made of the quality of the insurance and the services provided at home (CEPS, 2007). A survey of a sample of the users of home care benefits revealed a high to very high level of satisfaction. However, lack of transparency of the procedure (only 1 in 3 of beneficiaries said they understood it completely) and of its decisions (only 1 in 2 understood the care plan) was mentioned. Also the duration of the procedure was indicated as problematic. It is worth remarking that at this early stage there was substantial interest in the cash benefit: some 90% wanted to use either only it or it in combination with support in kind, and wanted to shift even more support in kind to cash (CEPS, 2007). Informal carers are mostly spouses or daughters. Those who use only benefits in kind do so because there is no informal carer available. In the first years, the IGSS reports that some 49% of beneficiaries of home care received it only as a cash benefit, while some 40% combined in-kind and cash benefits (IGSS, 2005:

203). Later there was a further increase in the share of persons who preferred either a combination of benefits in cash and in kind or the use of only support in kind (see Appendix 1). A system that was designed from the start to introduce cash benefits – and that was perceived as such – changed in reality to a relatively limited share of cash support (only 10% of total spending on LTC benefits). But this is, of course, also determined by differences in the cost of each kind of service and by the limitation in hours taken into consideration for the cash benefit. As illustrated further, residential care is more expensive, and persons are only eligible when they become more dependent (in need of more than 3.5 hours of care a week). The cash benefit does not increase any more when people need, say, 540 minutes of care per week at a relatively low level of dependency (category level 3 out of 15 categories). The system implies that when dependency becomes greater, there is no additional compensation in cash. It probably implies that from that point beneficiaries must seek professional help and care.

An important dimension of adequacy is availability and accessibility. In a recent study by Eurofound (2017), Luxembourg was situated among the best-performing countries, alongside the Netherlands, Belgium, Cyprus and Denmark, on issues of availability (waiting lists, lack of services) and access. There is no information in that study on the topic of ownership of residential care.

The presence of a well-developed long-term care insurance could have an impact on the availability of informal care and the potential for the main carer to combine care and work. As highlighted in the ESPN thematic report on long-term care and the work-life balance (Pacolet and De Wispelaere, 2016), 20.1% of the working population in Luxembourg claimed to take care of an older family member, either part time (19.2%) or full time (0.9%). This needs to be set alongside the European average of 16.4% of carers in the working-age population (2.8% full time and 13.5% part time). This could influence the gender employment gap (i.e. the difference between the employment rates of men and women of working age) and the percentage of part-time workers in total female employment. Although the country has a high employment rate, the gender gap in employment in Luxembourg is 12.9 percentage points, compared to 11.5 in the EU-28, while the share of part-time work for women is 35.7%, compared to 32.8% for the EU-28. In particular, the employment rate of women aged 50-64 is only 48% in Luxembourg, compared to 54.3% in the EU-28 (Pacolet and De Wispelaere, 2016: 12).

2.2 Planned reforms and how they address the challenges

In the past it was indicated in the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) report for the European Commission (Spruit, 2014) that, according to calculations by the IGSS, LTC insurance should remain financially stable until 2030, if the contribution rate is gradually raised from 1.4% to 1.7%. However, according to COPAS, even a contribution rate of 1.7% will not be sufficient if the growth rate of GDP remains low in the coming years. Likewise, Eurostat projections from 2013 and the European Commission's Ageing Report of 2015 estimate that the LTC expenditure will increase by 2060. The reform of the recent period seems to provide a more optimistic scenario for the sustainability of LTC insurance (see above).

Since the launch of the debate on this recent reform of LTC insurance, trade unions have been concerned about the maintenance of the care level for dependent persons and the level of employment. In October 2015, for instance, the OGBL trade union proposed increasing the state's contribution of 40% to 45%, introducing employer contributions and even increasing the general contribution of all incomes. It warned also that there could be a move to lump-sum reimbursement, instead of individual compensation schemes based on the actual allocated care time. It fears that the system could become less transparent and less controllable, which would be exactly the opposite of the ambitions of the new law.

In July 2016, the LCGB trade union said it regretted the rapid decision making (the government wanted to launch the new regulation on 1 January 2017). Despite the fact that not all stakeholders were convinced, the new legislation was adopted on 12 July 2017 (Frati, 2018).[5]

The relatively generous total spending on LTC is under pressure, if we observe the recent evolution of dependent persons and total spending. The present reform occurred within the context of the new fiscal plan.

The trade union could not agree with the new reform because of the austerity measures announced in the *Zukunftspak* (the Future Pact) (a cut of EUR 14.5 million in 2016 and of EUR 38.5 million in 2017). The budgetary implications presented in the new law illustrate, however, that the savings originally planned in the 'new generation budget' (*budget nouvelle generation* – BNG), taking account of European budgetary restrictions, are compensated partly in the new reform act. The original proposal for savings of some EUR 27 million for 2017 and 2018 was reduced to only EUR 13.8 million. The cost containment seems to be limited to 2.1% in 2017, 3.3% in 2018 and 4.5% in 2030, but the reform implies more transparency, more adequacy and more controllability.

The reform measures do not touch on how the LTC system is financed. The contribution rate and state participation stay the same (MSS, 2016). In the total revenue of EUR 605.6 million in 2016 the LTC premium accounts for EUR 373.6 million and the state contribution is EUR 217 million (IGSS, 2017: 132). The special levy on the energy sector is a symbolic contribution of EUR 1.9 million.

Applying the new fiscal guidelines (BNG) resulted in a freezing of the monetary value of the services rendered and more selective eligibility for the spending. The budgetary savings are, however, partly offset by some of the parameters of the new LTC law. On top of that, to allow the service providers a proper transition from the old regulation to the new, a digressive compensation mechanism is provided for 3 years, totalling EUR 30 million (Project de loi, 2016). The additional compensation mechanism from the state budget represented some EUR 11.1 million in 2016.

Despite the availability of cash benefits and their widespread use, their overall importance in the total offer of the LTC insurance remains limited, probably illustrating the priority given to in-kind support. Enlarging the scope of care leave and orienting the LTC insurance itself more to the reconciliation of work and care duties could be tackled in the future. A central role is foreseen in the latest reform for those people (mostly family members) taking care of a dependent person and enabling them to stay at home for as long as possible.

Several measures will be taken to support them better in their task. Some examples: training sessions, information sheets, etc. But at the same time, the sector itself fears that there is a reduction in support for some specific elements, such as 'courses' (COPAS, 2017b).

2.3 Policy recommendations

It is worth remarking that in its forecast for future expenditure, the reform law mentions: 'The results presented refer only to the protected resident population, because the information on non-residents is inadequate' (Projet de loi, 2016: 33).[6] Only a limited amount of social spending on LTC goes on cross-border and other mobile workers, in spite of the very high number of them in the Luxembourg workforce.

[5] See also: http://chd.lu/wps/portal/public/Accueil/TravailALaChambre/Recherche/RoleDesAffaires?action=doDocpaDetails&backto=/wps/portal/public/Accueil/Actualite/DossiersEnCours&id=7014

[6] In French: Les résultats présentés se rapportent uniquement à la population protégée résidente, étant donné que les informations sur les non-résidents sont insuffisantes.

This problem has been a point of concern in the past and returns in the present debate. The LCGB (2016) trade union mentions the pending problem of 175,000 cross-border workers (40,000 from Belgium) who have contributed to the financing of the LTC insurance system since it began, but who have only benefited from it in a limited way. It proposes: 'A bilateral covenant could prevent cross-border workers going to court and could solve the issue once and for all, instead of endangering the whole Luxembourg dependency insurance system. An adverse ruling by European juridical bodies (as in the case of reform of the scholarship system) could indeed involve an explosion in costs, putting in danger all current benefits.'[7] The trade union also asked for a proper settlement – by way of a bilateral covenant – of the coordination between the Luxembourg LTC insurance and the newly created LTC insurance in the Walloon Region of Belgium. This so-called 'new' LTC insurance is also emerging in other regions of Belgium, as a result of the Sixth State Reform in Belgium (Pacolet and De Wispelaere, 2018). But the LTC insurance already existed implicitly in the Belgian health insurance system or in existing regional regulations. There are similar systems in the other neighbouring countries of France and Germany. The issue shows the increasing need for a proper regulation within the health chapter of the European social security coordination.

Recently, the Luxembourg and Belgian trade unions LCGB and CSC again highlighted the problem, especially with the upcoming LTC insurance of the Walloon Region. Some 45,000 cross-border workers from Belgium risk having to pay two contributions for LTC, even though at present – since most of the benefits of the LTC insurance in Luxembourg are in-kind benefits, available in Luxembourg – they do not benefit when they retire. They request once again a proper solution, with a bilateral agreement between the Walloon and the Luxembourg governments on this matter (Frati, 2018).

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

There is a longstanding tradition of extensive reporting on LTC insurance in the general report on social security by the IGSS. In 2013, a first evaluation was also made of almost 15 years of development of LTC insurance. Most of the indicators used involved quantitative information on the beneficiaries, their profile, the services rendered, the suppliers, the personnel implications and the financial implications for LTC insurance, both for spending and for financing. Also, the build-up of reserves is monitored. In the chapter on LTC insurance, information is provided by the IGSS (2017: 89-135) on, among other things:

- the number of personnel
- the beneficiaries per age category, gender and care setting
- the average and median age
- the medical cause of dependency according to the ICD 10 (International Classification of Diseases 10th Revision) classification
- the allocated support in number of hours, according to age category, ICD 10 category
- the type of care and support according to instrumental activities of daily living (IADL) and activities of daily living (ADL)
- the cost of care, in cash or in kind according to setting, age structure, type of provider

[7] In French: Une convention bilatérale pourrait éviter des recours en justice de frontaliers et régler la problématique une fois pour toute de manière à ne pas hypothéquer le système Luxembourgeois d'assurance dépendance. Le cas échéant, une condamnation du Luxembourg devant des juridictions européennes pourrait entraîner comme dans le dossier des bourses d'études une explosion des coûts qui mettrait au grand final toutes les prestations actuelles en cause.

- total structure of revenue and spending of the LTC insurance and the evolution of the cumulated reserves. To assess the potential deficit/surplus, a so-called required 'equilibrium rate of contribution' is compared with the real rate of contribution of 1.4% of all income.

There is no clear distinction between disabled persons using those services and the elderly. That is as it should be from the point of view of the internationally agreed definition of long-term care and the internationally observed shift towards more integrated care systems. But it makes it rather difficult to formulate an exact description of the long-term care system for the elderly. In the regular reporting, there is also no reference to the prevalence of the use of those services (number of users in relation to the total population or the target population). It could, however, be revealing. For instance, even the simple ratio of the beneficiaries of residential care to the total population was some 0.8% in 2015. This reveals a rather restrictive residential care system compared to, for instance, Flanders in Belgium, where only the number of places for the elderly in residential care is already 1.3% of the total population (Pacolet et al., 2018: 60), revealing a system in Flanders that is much more oriented toward institutional care .

In the yearly reporting, no attention is paid to the quality of the services rendered or to the satisfaction of users.

There is no standard registration of co-payment in residential care (the *prix d'hébergement* and other supplements). Although some major providers (the sector is fairly concentrated) are very transparent about this dimension, the government could provide more transparency – not only for monitoring the sector, but also by informing the elderly and their families. Also, information on the quality of residential care – such as the number of single rooms or the number of square metres per room – could be provided. Information on the share of single rooms is, for instance, available from the register of LTC services provided by the Ministry of Family (Ministère de la Famille, de l'integration et à la Grande Région, 2016). This information could be used to develop an indicator on the dimension of quality of the residential care, the share in total number of rooms of single rooms.

Appendix 1

Cost comparison between institutional care and home care and total cash benefits, 2011-2016

Cost comparison between institutional care and home care and total benefits												
	2011		2012		2013		2014		2015		2016	
	Institution	Home	Institution	Home	Institution	Home	Institution	Home	Institution	Home	Institution	Home
Cost of care (in EUR million)	262.9	187.3	285.3	211.6	310.1	213.7	329.7	222.4	327.5	220.5		
Number of beneficiaries	3,931	8,457	4,149	8,857	4,253	9,125	4,388	9,102	4,497	9,045	4,560	9,182
Unit cost in EUR (= per beneficiary)	66,879	22,147	68,764	23,891	72,913	23,460	75,136	24,434	72,826	24,378		
Unit cost (as % of GDP per capita)	84%	28%	84%	29%	84%	27%	83%	27%	79%	26%		
Cash benefits at home												
	2011		2012		2013		2014		2015		2016	
Cash benefits (in EUR million)		51.0		53.4		54.6		55.9		53.4		
Cash benefits (as % of total benefits)		11%		11%		11%		10%		10%		
Number of beneficiaries of cash benefits		6,337		6,655		6,802		6,764		6,608		6,607
Unit cost (cash benefits per beneficiary)		8,048		8,024		8,045		8,264		8,081		
Unit cost (as % of GDP per capita)		10%		9.74%		9.29%		9.08%		8.73%		

Combined use of in-kind and cash benefits in home care, numbers and as % of total							
Number of beneficiaries of only in-kind benefits			1,563 (19%)	1,639(20%)	1,748 (21%)		
Number of beneficiaries of only cash benefits			1,017 (12%)	1,166 (14%)	1,309 (16%)		
Number of beneficiaries combining cash and in-kind			5,747 (69%)	5,442 (66%)	5,298 (63%)		
Total			8,327 (100%)	8,247(100%)	8,355(100%)		

Source: IGSS (2017: 117).

Appendix 2

Past, recent and future evolution of the number of beneficiaries of long-term care insurance 2000-2015-2016-2030, number of persons

	Most recent evolution							Evolution in the past and projections for the future				
	2011	2012	2013	2014	2015	2016	Index 2016 (2011=100)	2000	2015	2030	Index 2015 (2000=100)	Index 2030 (2015=100)
Residential	3 931	4 149	4 253	4 388	4 497	4 560	116	2 372	4 563	6 346	192	139
Home	8 457	8 857	9 125	9 102	9 045	9 182	109	3 363	8 815	11 742	262	133
Total	12 388	13 006	13 378	13 490	13 542	13 742	111	5 735	13 378	18 088	233	135

Source: Appendix 1 and Inspection Générale de la Sécurité Sociale (IGSS) (2013b)

Appendix 3

Providers in the long-term care sector and their personnel, compared to the total budget and number of users, 2015 and 2016

	Providers	Personnel		Beneficiaries		Budget cash benefit included		Budget without cash benefit	
	2016	2015		2016		2016		2016	
	Number	Number of personnel	As % of total	Number	As % of total	EUR million	As % of total	EUR million	As % of total
Home care setting									
Home care and help	24	2 442.5	26%						
Outpatient care centre	53	443.1	5%						
Total home care	77	2 885.6	31%	9 182	67%	223.0	40%	169.6	33%
Residential care setting									
Temporary stay	42	1 011.2	11%						
Permanent stay	52	5 530.4	59%						
Total residential care	94	6 541.6	69%	4 560	33%	339.0	60%	339.0	67%
Total LTC sector									
Total LTC sector	171	9 427.2	100%	13 742	100%	562.0	100%	508.6	100%
Total LTC sector in FTE		6 594.1							

Source: Table 1 and IGSS (2017).

Appendix 4

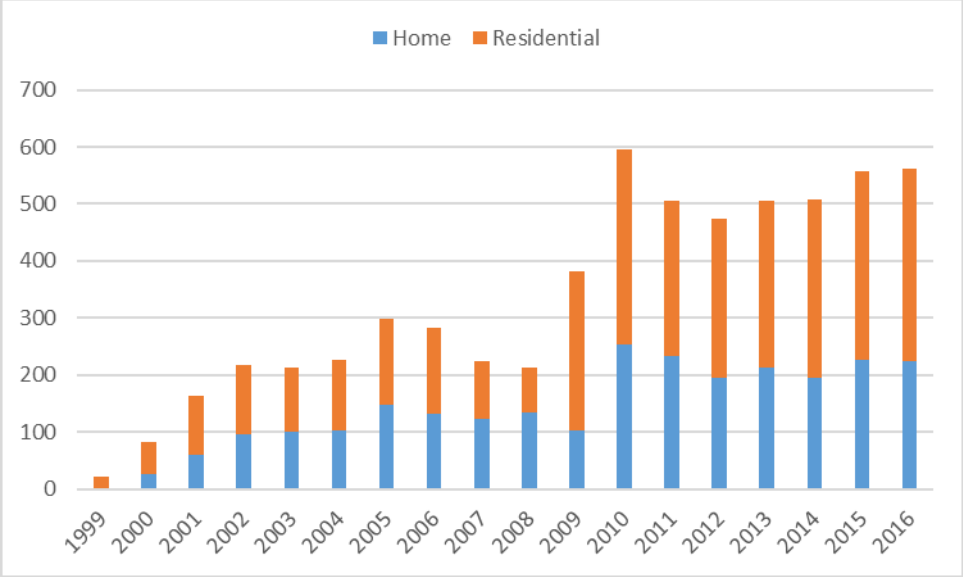
Dependency categories and benefits in kind and in cash in the Luxembourg LTC insurance since the reform of 2018

Dependency category		Benefit in kind				Benefit in cash		
		Residential care		Home care		Only in home care setting		
Category	Time in minutes of help needed each week	Category	Minutes per week compensated	Category	Minutes per week compensated	Category	Weekly time of informal care	Weekly benefit in EUR
				Forfait 0	125	Forfait 1	less than 61 minutes	12.50
Level 1	210-350 minutes	Forfait 1	280	Forfait 1	280	Forfait 2	61-120 minutes	37.50
Level 2	351-490 minutes	Forfait 2	420	Forfait 2	420	Forfait 3	121-180 minutes	62.50
Level 3	491-630 minutes	Forfait 3	560	Forfait 3	560	Forfait 4	181-240 minutes	87.50
Level 4	631-770 minutes	Forfait 4	700	Forfait 4	700	Forfait 5	241-300 minutes	112.50
Level 5	771-910 minutes	Forfait 5	840	Forfait 5	840	Forfait 6	301-360 minutes	137.50
Level 6	911-1,050 minutes	Forfait 6	980	Forfait 6	980	Forfait 7	361-420 minutes	162.50
Level 7	1,051-1,190 minutes	Forfait 7	1,120	Forfait 7	1,120	Forfait 8	421-480 minutes	187.50
Level 8	1,191-1,330 minutes	Forfait 8	1,260	Forfait 8	1,260	Forfait 9	481-540 minutes	212.50
Level 9	1,331-1,470 minutes	Forfait 9	1,400	Forfait 9	1,400	Forfait 10	more than 540 minutes	262.50
Level 10	1,471-1,610 minutes	Forfait 10	1,540	Forfait 10	1,540			
Level 11	1,611-1,750 minutes	Forfait 11	1,680	Forfait 11	1,680			
Level 12	1,751-1,890 minutes	Forfait 12	1,820	Forfait 12	1,820			
Level 13	1,891-2,030 minutes	Forfait 13	1,960	Forfait 13	1,960			
Level 14	2,031-2,170 minutes	Forfait 14	2,100	Forfait 14	2,100			
Level 15	More than 2,170 minutes	Forfait 15	2,230	Forfait 15	2,230			

Source: Own synthesis of information in the Projet de loi (2016).

Appendix 5

Figure 1: Expenditure on long-term care for residential and home care, in EUR million, 1999-2016



Source: Le portail des statistiques, Grand-Duché de Luxembourg.

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