ESPN Thematic Report on Inequalities in access to healthcare

Luxembourg

2018

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June 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

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http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

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Summary / Highlights

The Luxembourg healthcare system can be described as inclusive, generous and of high quality. Everybody, regardless of living circumstances and economic activity, has the same access to it. The system is funded from general taxation (40% of the budget) and social contributions (5.6% of all occupational income, split equally between employers and employees).

Funding is based on social contributions and coverage is universal (almost 96%; the remaining 4% are covered by European institutions or foreign schemes). Several measures have been taken to ensure financial support for those who cannot afford the contributions.

The availability of healthcare in Luxembourg is good and there is scarcely any unmet need for reasons of unavailability.

Co-payments by patients are generally limited and may not exceed 2.5% of taxable income. But medical care costs have to be prepaid by the patient and are reimbursed afterwards. For those who cannot afford the prepayment, a benefit-in-kind model exists and the patient's co-payments can be undertaken by the local social office, if necessary.

Some small differences in access to healthcare do remain because of the cost. Generalised direct payment of medical care by the national insurance authorities (*tiers payant social*) – a proposal currently being debated – would address these differences.

The organisation Doctors of the World (Médecins du monde) has flagged up the issue of people not using (or not being included in) the formal healthcare system. Many steps have been taken to include all residents in the healthcare insurance system; yet a (small) number of people still fall through the safety net. This remains a challenge to the outreach of public and private social and health services. Even if some people are so-called 'avoiders', persistent efforts must be made to include them in the system and to help them claim their basic rights to healthcare.

The indicators used to measure access to healthcare in a comparative perspective are adequate as far as Luxembourg is concerned. Reports on social inclusion in Luxembourg show that single-parent households and migrants are the population groups most at risk of poverty. For regular migrants, the 'unmet need' indicator is included in the Eurostat database. It would be helpful also to have a breakdown by household type.

There is little information about those people who are not included in (or who do not use) the formal care system, but who instead use for example the services of Doctors of the World. The only way to get more information about this would be to undertake in-depth qualitative research to include both the population concerned and the public and private social and health services.

1 Description of the functioning of the country's healthcare system for access

Based on the principle of universal **coverage**, the Luxembourgish healthcare system offers a comprehensive package of health services both to residents and to the population working in the country. Contribution to the principal public health insurance CNS (*Caisse National de Santé*) is mandatory for all economically active persons (employed, self-employed or recipients of replacement benefits).[1] The contribution rate to the national health insurance currently stands at 5.6% of all occupational income. This represents 60% of the healthcare budget and is split equally between employers and employees. The state pays the remaining 40% of the budget. The insurance covers family members, as well as minors and students in Luxembourg without any other health insurance coverage. There are three health insurance institutions that operate separately – for civil servants and public employees at the national and commune level, and for employees of the national railways. Although separately managed, they apply the same contribution and reimbursement rules as the CNS (MSS, 2018: 86-87). This system results in a coverage rate of 95.9% (2015) of the population. The remainder mostly work either for the European Commission or abroad and are thus covered by foreign schemes (JAF health first and second step analysis Luxembourg, p. 6). Luxembourg's per capita expenditure on health is the highest in the EU: EUR 5,557 in 2015. As a percentage of GDP, however, it is, at 6%, lower than in many other EU Member States.[2]

The state covers 9.07% of this expenditure; 72.92% comes from the compulsory insurance schemes; 7.37% from voluntary schemes; and 10.64% from household out-of-pocket payments. Only France has a lower percentage covered by out-of-pocket payments.[3] The voluntary schemes in Luxembourg are supplementary (private) insurance policies to cover out-of-pocket payments or to provide extra services (not covered by the healthcare system). Voluntary schemes and out-of-pocket payments together represent 18.01% of all health expenditure, which is low compared to most other EU Member States. This can be explained by the depth of coverage, which has even increased in recent years.

A particular characteristic of Luxembourg's health insurance context is the difference between the number of insured persons and the resident population. Only 66% of the population covered by national health insurance was actually living in Luxembourg in 2016, since there are huge numbers of incoming cross-border workers (and their family members) who belong to the Luxembourgish health insurance system by virtue of their professional activity. The number of insured residents in 2016 increased by 1.9% over 2015, but the number of insured non-residents increased by 3.8%, to reach 276,701 out of a total of 813,124 insured persons (the total population of Luxembourg was 590,700 on 1 January 2017) (CNS, 2017: 124). Clearly, the non-resident insured play a role in the financial viability of the Luxembourg health insurance system.

Those who receive replacement income are automatically covered; those who do not receive replacement income, but nevertheless cannot afford the health insurance contributions can request financial support via the local social offices. The self-employed and the economically inactive must pay their contributions themselves. If they do not, there are procedures in place to force them to pay, plus costs. In the meantime, their coverage continues.

The Luxembourg healthcare system offers good **availability** of health services. A major reform started in 2010 and was followed by several steps to clarify and improve the role

[1] Here replacement benefits refer to sickness, maternity and unemployment benefit, invalidity, old age and survivors' pensions, guaranteed minimum income, etc.

[2] Eurostat - [hlth_sha11_hc] – extracted on 23 April 2018.

[3] EU SILC 2016 downloaded on 13 April 2018.

of different actors and to improve the effectiveness and efficiency of the institutions. Patients' freedom of choice and the position of physicians as liberal professionals remain basic principles of the system. The introduction of an eHealth platform has had a positive impact on the modernisation of the health system and is making a major contribution to the quality of care, as patients' medical information can be shared much more easily than before. The security features of the planned system are more rigorous than is currently found in any other country (Hohmann and Benzschawel, 2013). The most recent (already the sixth) edition of the so-called *Carte Sanitaire (2015)* was published in June 2016. This document serves as a decision-making tool for the strategic orientation of the Luxembourg hospital sector. It provides information on the existing availability and use of general hospital services and on the specialised services of national importance. It also provides information about the expected demand for services and healthcare staff based on national demographic and health status projections (SANTE, 2016).

In 2015, Luxembourg had 2.9 physicians and 12.3 nurses per 1,000 inhabitants.[4] In 2016, there were 4.8 hospital beds per 1,000 inhabitants.[5] The number of physicians is lower than in many other EU Member States, while the number of nurses is higher. The ratio per 1,000 inhabitants has remained more or less stable over the past few years, despite the rapidly growing population (+9.5% over the past 5 years, i.e. from 549,680 inhabitants in 2014 to 602,005 in 2018).[6] The low ratio of physicians does not seem to affect the figure for unmet need due either to waiting times (0.1%) or distance (0%).[7]

The **affordability** of healthcare in the Luxembourg system is affected not so much by the (limited) co-payments, as by the fact that the patient has to prepay for every medical treatment and then apply for reimbursement (which can amount to 80-100% of the standard set fees, depending on the services provided). The costs of hospitalisation, medicines, laboratory analyses and physiotherapy are offered as a benefit in kind and only require the patient to pay the service provider for anything over and above. Overall the co-payment for statutory health services is limited to a maximum of 2.5% of the taxable income of the insured.

In the system of prepayment of medical costs by the patient, persons on low income would often have difficulty paying their healthcare expenses, and would therefore postpone or even forgo certain treatments. Therefore, from January 2013 the government introduced a benefit-in-kind model (*tiers payant social*). The local social offices certify that a person is in financial difficulties. The certificate is valid for 1 year. In such cases, medical and dental treatment is paid directly by the national health insurance authorities. The patient's own contribution (e.g. 12% for a consultation) is assumed by the local social office. The costs involved include the patient's co-payments and the cost of administering the model and are shared equally by the state and the municipalities. A similar system exists for long-term care: if an elderly person cannot afford the co-payment for the accommodation cost in residential care, the *Fonds National de solidarité* can allow a *complément accueil gérontologigue* to balance the person's contribution with his/her income. Pocket money of EUR 441.85 per month is safeguarded. The intervention of the *complément accueil gérontologique* depends on the beneficiary's income, but also on his/her financial and real estate assets. In the latest year for which data are available, some 15% of people in homes for the elderly applied for this assistance (Pacolet and De Wispelaere, 2018).

It is currently being debated in parliament and by the different stakeholders whether the system of direct payment of medical costs by the health insurance authorities should be extended to the whole population. That would leave the patient to pay only the costs not covered (co-payment). Advocates of the idea (supported by a petition with 6,700

[4] EU SILC 2016 downloaded on 13 April 2018.

[5] OECD – Health statistics 2017.

[6] STATEC (Statistics Luxembourg) Database – extracted on 24 April 2018.

[7] EU-SILC 2016.

signatures) maintain that the current model stigmatises the poor, and point to the 225,000 or so cheques (each costing EUR 4 for administration) that were sent out in 2016 as an advance of the reimbursements. Opponents cite the administrative difficulties linked to the proposal and the possible loss of freedom for both patient and doctor. It looks likely that there will be a political majority in favour of a phased expansion.[8]

The CNS signs regular agreements with each of the health professional associations on the pricing of different medical interventions. All medical professionals are obliged to use these tariffs. This makes the cost of healthcare the same for all residents.

There are **health inequalities** in Luxembourg, particularly between different income groups; but there is no evidence that these are linked to inequalities in access to healthcare. There could be a link to the reach of prevention campaigns, but there is a lack of more in-depth studies. There is, for example, a clear difference in the daily smoking rate between the first and the fifth income quintiles (13.1 percentage points higher in the first quintile in 2015). This figure is higher than the EU-28 average difference of 7.8 percentage points. At the same time, the regular daily smoking rate is, at 14%, lower in Luxembourg than the EU-28 average (15.5%). For obesity, however, the gap between the different quintiles is very low (2.6 percentage points), while the obesity ratio (5.6%) is about the EU-28 average (5.8%).[9]

To conclude, we endorse the assessment of the Luxembourg healthcare system by Caritas Luxembourg (Schmit, 2016: 323-325), which highlights the relatively high level of performance. Everybody, regardless of their living circumstances, has the same access to the healthcare system. Coverage is universal; financing is guaranteed by social contributions and general taxation; and patient co-payment is limited (some 7%). The risk of unmet healthcare needs for those people living in precarious circumstances has decreased in recent years. The impact of sickness on the poverty level is rather limited.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The conclusion of the previous section relates to the characteristics of the healthcare system. These can be considered 'good practice', as they ensure good coverage and universal access to equal and quality healthcare services that are (in principle) affordable.

What unmet need there is for medical care due to cost can be seen as a result of the payment system in Luxembourg; however, the figure for unmet need is low (0.3% in 2016).[10] It was somewhat higher between 2012 and 2015 (0.8% in 2013). The EU-28 average stood at 1.6% in 2016, but this figure is much influenced by a few high percentages (EL, IT, LV, RO). Without these, the average would be 0.8%. The gap in unmet need for medical care – i.e. the difference between the first and the fifth quintile income groups – is also low in Luxembourg. It did increase between 2007 and 2013, when it reached 2.4 percentage points; but it has since decreased to stand at 1 percentage point in 2016, while the EU-28 average was 3.9 percentage points. The figure for Luxembourg was higher than that for Germany (0.6), but lower than for Belgium (7.6) or France (2.9).[11]

The overall unmet need for medical care stood at 0.4% in 2016. If we look in more detail at personal characteristics, we find no difference between men and women in unmet need and almost no difference as far as educational levels are concerned. The same goes

[8] See e.g.: http://paperjam.lu/news/un-tiers-payant-generalise-en-etapes?utm_medium=email&utm_campa, and http://paperjam.lu/news/lammd-denonce-les-derives-du-tiers-payant?utm_medium=email&utm

[9] EU SILC 2016 downloaded on 13 April 2018.

[10] EU-SILC 2016.

[11] EU-SILC 2016.

for different age groups, with one exception: for the 65+ age group unmet need is 0%. For the unemployed, however, the figure for unmet need stood at 1.4% in 2016 (EU-28 average 5.3%), which seems to indicate that here is a challenge for better access (although Luxembourg is still the seventh-best performer in the EU-28 in this respect).[12] Migrants are particularly vulnerable in terms of social exclusion in Luxembourg. Therefore, we also looked at unmet need for medical care due to cost in relation to country of citizenship: between Luxembourg nationals (0.3%) and third-country nationals (non-EU-28: 1%) we see a difference of 0.7 percentage points.[13]

A generalised direct payment of medical care by the national insurance authorities (the *tiers payant social* currently under debate) would be one answer to the remaining differences in access.

However, access to healthcare in Luxembourg can be problematic if people do not fulfil the basic conditions for being fully included in the system. As in other social policy domains, this concerns the most vulnerable population categories: homeless persons, undocumented migrants, drug-dependent persons and others who fall through the social protection 'safety net'. There are no recent studies on this, but a report by Doctors of the World Luxembourg gives an indication of the various groups affected (Médecins du Monde, 2017).

In 2016, 591 persons visited the organisation for a consultation; 75% of them were not covered by health insurance. In 2017, the number of consultations increased dramatically, and the organisation dealt with 784 persons (Médecins du Monde, 2018: 1). An important barrier to social protection inclusion is the condition of so-called '*domiciliation*' that must be met. A person can only apply for health insurance if he/she has an official address, registered in a municipality. A second barrier is that a person has to have an income from work or a replacement income in order to be covered or to be able to pay the health insurance contributions. A third barrier is the ability to 'read' the system, which requires language skills and administrative capacity. This may be an issue, for example, when a patient applies for the benefit-in-kind model (*tiers payant social*) to avoid having to prepay care costs. According to Doctors of the World, the population with limited or no access to healthcare can be divided as follows:

- Homeless people with no coverage because they have no address;
- People who have a home and an official address, but:
    - have lost their minimum income rights and consequently their health insurance subscription;
    - have a health insurance subscription but are in great (financial) difficulties;
- People who have a home, but not an official address:
    - EU citizens who are unable to prove sufficient financial resources and are thus considered irregular migrants;
    - Third-country irregular immigrants;
- Sex workers, drug addicts and alcohol-dependent persons.

A question about the Doctors of the World report was raised in parliament. In response, the Minister of Family, Integration and the Greater Region and the Minister of Social Security said there were no figures on non-insured persons. Furthermore, they recalled the possibility for any person with new residence in Luxembourg to pay a voluntary health insurance contribution for an initial period of 6 months. For those who do not have an official address, there are other ways of proving residence: for example, proof of shelter or proof of accompaniment (as a newcomer) by a public institution or a non-

[12] EU-SILC 2016.

[13] EU-SILC 2016 ([hlth_silc_30] – extracted on 8 May 2018.

governmental organisation. The situation of such persons is monitored every 6 months and reported to the Minister of Social Security. In December 2017, 355 persons without a legal address in Luxembourg were recorded by the Ministry as having voluntary insurance. Of these, 40% were Portuguese, 7% had Luxembourg nationality and 18% came from other EU countries. The remaining 35% were third-country nationals. The ministers mentioned that the Ministry of Health has a budget to cover the medical care costs of non-insured persons; and finally, they recalled that it is the job of local social services to help people in need to enter the social protection and health insurance systems.[14]

It is clear from the above that many measures and actions have been taken to include all residents in the health insurance system. But it is also clear that a (small) number of people still fall through the safety net. This seems to be mostly a challenge to the outreach of public and private social and health services to help as many people as possible to claim their basic rights to healthcare, even if they are so-called 'avoiders'.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Access to healthcare is generally good in Luxembourg, and the indicators used to measure it in a comparative perspective are adequate (European Commission, 2015: 23-24). The affordability of care is the only aspect of access where there are differences between population groups. Reports on social inclusion in Luxembourg show that single-parent households and migrants are the population groups most at risk of poverty. For migrants, the indicator breakdown of unmet need is included in the Eurostat database. It would be helpful also to have a breakdown by household type.

As this report shows, there is little information about persons who are not included in, or who do not use, the formal healthcare system. Possible reasons could be barriers in terms of cultural background, language issues or lack of administrative competence – albeit there are many measures and actions in place to overcome these barriers. There could also be a number of 'avoiders'. The only way to know more about this phenomenon would be to undertake in-depth qualitative research, including both the population concerned and public and private social and health services.

[14] See: https://chd.lu/wps/portal/public/Accueil/TravailALaChambre/Recherche/RoleDesAffaires?action=doQuestpaDetails&id=15965

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