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Pensions, Health and Long-term Care

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1 Executive Summary

Luxembourg's social security system is largely based on principles of solidarity, which guarantees generous pension benefits as well as universal access to comprehensive health and long-term care services, and is financed as a pay-as-you-go (PAYG) system with large governmental participation. Policy-making is characterised by consensus and concerted action.

In the period before the financial crisis, the country has not been challenged by major economic constraints such as budget deficits or unemployment, placing the social security system at risk, for some long time. The current crisis changed this situation drastically and gave an important lesson that even for a small, specialised and open economy like Luxembourg, the strong and continuous growth experienced for so long cannot be taken for granted.[1]

Since the economy has been affected, substantial adverse effects on the national labour market and on fiscal sustainability have ensued. The governmental consolidation plan envisages re-establishing a small surplus within five years by setting an annual consolidation target of around 1% of GDP.[2]

One part of the deficits are planned to be covered by raising existing taxes, limiting tax reductions or implementing additional taxes (i.e. for financial transactions). Furthermore, wage indexation might become subjected to an adjusted basket of goods (excluding the prices of fuel and some other excise products). Savings on expenditure, in particular for social transfers to households, are intended to make up the rest of the consolidation plan. Especially social benefits such as child benefits above the age of 21 and interest subsidies for property ownership are under scrutiny. With regard to pensions, the bi-annual wage adjustment is proposed to be reduced and/or distributed to two years (2011 and 2012).[3]

Fortunately, Luxembourg's pension system is still in a very favourable demographic and financial situation. In 2008, the accumulated reserve still amounted to as much as 3.56 times yearly expenditure, which equals 28% of GDP.[4] However, in the long-term, the sustainability of the pension fund is anything but secured. The changing demographic profile of the system, which currently enjoys the above-mentioned high percentage of young (cross-border) workers, along with very generous benefit entitlements and very high legitimate claims, and the general dependency of all social security expenditure on public co-funding[5] combine to place the pension fund system, and with it social cohesion and political stability, at high risk in the long-term. This situation permits preparation for an effective reform, even during the crisis, without jeopardising the fundamental structure of the system or being compelled to introduce sharp cuts in benefits.

1 OECD 2010, 95.

2 MF 2010, 16.

3 Prime Minister's State of Union speech on 5 May, 2010 (www.wort.lu) accessed on 5 May 2010. See also: http://www.mf.public.lu/actualites/2010/04/frieden_tripartite_130410/index.html (accessed on 20 April 2010).

4 At the end of 2008, the contribution to the reserve fund corresponded to 32.2% of current expenditure. The total reserve amounted to EUR 8,897 million (IGSS, Nov 2009, 208).

5 The government's financial participation amounts to 33% in the pension fund, roughly 37% for both the health insurance fund (benefits in kind) and the long-term care insurance. Additionally, maternity benefits and contributions for people below the minimum income level are fully covered by the public budget. See: www.statsecu.etat.lu Total des contributions de l'Etat [RG/AM/IGSS, 2008], RG/A-D/IGSS, 2008], [RG/AP/IGSS, 2008].

Logically, the structural slowdown in employment growth caused by the crisis will result in an additional shortage of financial resources. This new burden for the pension system will also affect the financing of health and nursing care, which will additionally enlarge age-related spending and, in the current system, will likewise depend on additional public co-funding.

A first rough impact analysis of the economic and financial crisis on the various branches of social security currently guides the national debate on necessary austerity measures to keep the systems and the public budget in balance.[6] The health sector, which enjoys an excellent reputation with the public and among international experts for its outstanding quality of services[7] is nonetheless challenged in that the costs tend to get out of control. Recently the financial crisis made it irrevocably clear that partial corrections to the structure of the existing system are absolutely vital. The enormous endeavours undertaken since autumn 2009 by the decision-makers demonstrate that they have not only realised this necessity, but are also trying to jointly identify tailor-made strategies to the country-specific problems. There is little or no sign of simplistic copies of foreign health system components among the various proposals.[8]

Unfortunately, whichever of the interesting reform proposals for the health system the government decides to prioritise, they will be assessed against the background of all the other austerity measures that will affect businesses, the labour market, the public and individuals' households. Opponents of structural reforms in health will therefore have ample room for provocative arguments to align public opinion with the view that reform will only sacrifice the quality of health care.

For long-term care, the government's impetus to foster quality improvements, enhance standardisation, strengthen technical progress and master system inefficiencies has shown first results. The implementation of more effective and transparent procedures to assess the dependency status and evaluate the volume and specificity of the support needed also help to increase people's faith in the administrative system. However, there is still room to improve information on the quality and the relevant prices for long-term care sercives and nursing home accommodation.

The system-wide unified analytical accounting system, which was developed over the last three years, is now in its inception phase and will have to demonstrate to live up to expectations. For the hospital sector, it already serves as an example to achieve greater transparency in pricing and planning.

2 Current Status

2.1 Pensions

2.1.1 Overview of the system's characteristics, reforms, debates, political discourse and scientific assessment

The public pension system in Luxembourg is organised as a pay-as-you-go (PAYG) system and covers the whole of economically active society on a mandatory basis. Since 1911 the system has evolved from a blue-collar workers' plan and reached its current universal dimension as long ago as 1964, when it encompassed independent workers as the last eligible group. Over the years, the four original private sector schemes were harmonised.

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6 MF 2010.

7 OECD 2008, Health Consumer Powerhouse 2009, TNS-Ilres 2009.

8 AMMD, Le Corps Médical 2010, 3-4/2010.

Pension benefits are calculated on both length of contributions and the accumulated lifetime amount[9] and are linked to two indices: the consumer-price and the wage index. Price-linking becomes automatic as pensions directly follow increases in the consumer-price index. If the six-monthly cost-of-living index exceeds the index for the preceding period by 2.5%, an index-linked increase is made to pensions the following month. Wage indexation on the other hand is done bi-annually by means of a specific law. Every two years the government proposes to the Chamber of Commerce an appropriate wage indexation that takes into account the financial resources of the pension scheme and the evolution of the average level of wages and income. The last adjustment became effective from 1 January 2009.[10]

The old-age pension is composed of three major shares that are paid in one-twelfth instalments:

- A lump sum of 27% of the minimum income for up to 40 years of an insurance career, taking into account both the periods of contributions and those countable periods without contribution (studies, child-raising, etc)
- A pro-rata enhancement of 1.85% of the sum of lifetime contributable wages and income
- An additional increase of 0.01% of the pro-rata enhancement for each contributable year exceeding both the age of 55 and 38 countable pension years (up to a total maximum of 2.05%)

The public pension system guarantees a minimum pension provision for an insurance career of at least 20 years. The minimum pension is set for a 40-year career and reduced by 1/40 for each missing year below 40. The average gross pension amounts to EUR 3,000 per month. However, 25% of pensioners receive a pension below EUR 1,750 and another 25% between EUR 1,750 and 3,000.[11]

In order to become eligible for a pension at the age of 65, a minimum of 10 contributable years have to be met. Early retirement is possible from the age of 60 by fulfilling a total of 40 pension or countable years with a minimum of 10 mandatory insurance years. In the case of 40 mandatory insurance years, a person can qualify for early retirement from the age of 57 onwards.

Civil servants and other employees of the government, local authorities, public institutions and the national railway, have their own separate statutory pension system. For public service employees who entered the public service from 1999, a so-called new special pension system is in place. It differs from the general public system only in the application of income ceilings for the assessment of the contributions. A second, so-called transitional special system exists for civil servant and people treated as such, who were in post before 1999. This system determines the pension on the final salary earned by the individual. For the years after 1999,

9 Accrued benefit rights also encompass periods of involuntary unemployment and temporary work-incapacity due to illness and accidents.

10 Art. 225 of the Social Security Code. The latest increase of 2%, which equals the wage increase of 1.3% in 2006 and 0.7% in 2007, became effective as from 1 January 2009. (Law of 19 December 2008). In contrast, in 2006 the Chamber of Delegates decided to postpone the January 2007' adjustments to July 2007 (by 1%) and July 2008 (by 0.9%) in order to consolidate public finances (Law of 22 December 2006). A potential reduction or even interruption of the wage indexation for the years 2011 and 2013 is currently under consideration. http://www.mf.public.lu/actualites/2010/04/frieden_tripartite_130410/index.html (accessed on 22 April 2010).

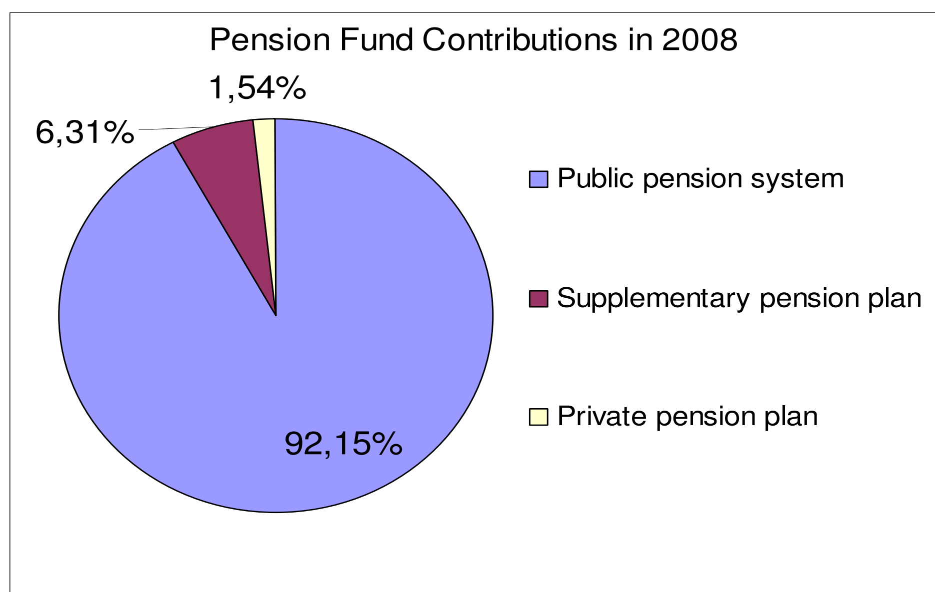
11 Genevois 2010, 1.

the replacement rate is lowered steadily from 83.33% to 72%. However, some full-career bonuses may still entitle the pensioner to a 83.33% replacement rate.[12]

Governmental reports and analyses on the pension system are regularly made available for the public through the governmental websites (www.etat.lu). The members of the pension funds are informed via mail on a yearly basis about their acquired years of pension rights. A preliminary determination of the pension amount to be expected is only made on request. However, according to the AXA pension survey 2009, roughly 38% of the active population is not aware of the amount of their future pension.[13]

The second and third pension tiers play an increasing but still marginal role in Luxembourg. Based on an estimated overall contributory amount of EUR 3,789 million in 2008 to all pension systems together[14], the public system alone represents 92.15% of all pension investments, followed by the supplementary company-based pension plan with 6.3%, and the private insurance-based plan of the third tiers at 1.55%. Whereas roughly 25% of the active population benefits from a supplementary pension fund, the same is true for only 15% for the third tier pension plan. For 2009, the Supervisory Authority of Insurance Institutions (Commissariat aux assurances) reports an increase of 18.52% of annual contributions to the third tier.[15]

Figure 1: Annual contributions to the different tiers



Source: IGSS 2009, Kneip 2008, Wictor 2009, Commissariat aux Assurances 2010, own calculations.

[12] European Commission, October 2009, 242.

[13] AXA 2009, 9. Despite the increase of 13 percentage points against the survey 2007-2008, the Luxembourg population still feels badly informed. See also: AXA 2008, 37.

[14] www.statsecu.etat.lu, Pension Insurance, Données financières, [RG/AP/IGSS,2008] ; Kneip, 5 ; Commissariat aux Assurances, 2010 ; own calculation. The public system includes both, the general public pension system and the special civil servant scheme. As any information for the second tier is only available for 2003, the increase in contributions between 2003 and 2007 has been set equivalent to the increase of the number of supplementary pension plans, a method that is also used by Wictor 2009.

[15] Wictor 2009, 8. Commissariat aux Assurances, 2010.

The financial model of the public system is based on a contribution rate fixed for a period of seven years, a government participation of 1/3 of the individual pension contribution (= 24% of gross salary in total)[16] and a reserve fund for compensation. Thanks to the extraordinary economic growth over the previous decades, the current low old-age dependency rate and the significant share of resident foreigners and cross-border workers in domestic employment,[17] the accumulated reserve amounted to 3.56 times yearly expenditure in 2008, which equals 28% of GDP.[18] Furthermore, cautious investment rules (less than 2% is invested in shares) granted the Luxembourg pension fund respite from the hazards of the financial and economic crisis.

Despite its currently wealthy financial situation, the pension insurance system is subject to a number of risks, which may in the long run and without any countermeasures leave it precariously in deficit:

- Low effective retirement age due to early retirement.
- High unemployment and work incapacity of older people aged 55 to 64 years.[19]
- Change of general demographic pattern, characterised by an increasing life expectancy in combination with an exceptionally large number of new retirees from 2020 due to today's disproportionately youthful foreign and domestic labour force.
- Very generous pension benefits with an average replacement rate close to 100%.

In order to keep the financial system in balance, the General Inspection of Social Security (IGSS) re-analyses the financial situation of the pension fund every seven years, which last happened in 2005. In 2005, the actuarial projections encompassed for the first time a long-term period up to 2050. IGSS estimated the level of public spending on pensions at roughly 14.2% of GDP in 2030 and 23.9% in 2060,[20] which will by then greatly exceed the EU average. This approach gave rise to doubts for the first time about the system's financial sustainability.

In response to the ongoing debate, a national pension working-group, composed of representatives of various ministries, IGSS, pension fund managers and social partners, was established in autumn 2007. This committee has been entrusted with evaluating the system's performance and developing strategies to adapt the pension system to demographic and structural changes in order to guarantee future pension commitments with stable, adequate revenues, and also to safeguard the achievements of a minimum pension based on both inter-generational and cross-generational solidarity. Questions on how to increase the effective retirement age and how to overcome drawbacks related to work incapacity and professional reintegration measures are central to this discussion. This group has considered a series of channels to ensure the sustainability of the pension system. They encompass various scenarios

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[16] The contributions are paid in equal shares of 8% by employers, employees and the state.

[17] The enormous boom between 1980 and 2000 with an average growth in GDP of more than 5% has also led to a substantial increase of migrant and cross-border workers. Consequently, the share of foreign population rose from 18% in 1970 to nearly 37% in 2001. In domestic employment, the share of Luxembourg nationals has dropped to 35.5% in 2001, while shares of resident foreigners and cross-border workers represented 27% and 37.5% respectively.

[18] At the end of 2008, the total reserve fund attribution corresponded to 32.8% of current expenditure and increased the total amount of the reserve fund to EUR 8,897 million (IGSS, Nov 2009, 208). See also MF 2010, 22.

[19] In 2006, the average retirement age was at 58, representing one of the lowest of all the Member States of the EU. In contrast, life expectancy increased and evolved for women at the age of 60 from 78.8 years in 1970 to 83.1 years in 2008 and for men from 75.1 to 78.1 respectively. (Statec 2010, 28). Eurostat projections for 2060 anticipate a further increase of 5 years for both women and men (Eurostat EUROPOP 2008).

[20] European Communities 2009,88. See also: European Commission 2009, 246.

to adjust existing parameters to determine contribution and benefits as well as eligibility conditions with regard to noncontributory benefit rights.[21] The group used as its main reference source the projections undertaken by Luxembourg experts in 2008 in the framework of the EC Ageing Working Group (AWG). The final report was published on 21 April 2009.[22]

In its declaration of 29 July 2009, the newly elected Government confirmed to develop a strategy for a pension reform guided by principles of linking the active working life to longevity, to ensure equity of disposable income between working population and pensioners, to guarantee an adequate level of pensions and to avoid poverty among pension beneficiaries.[23] Later, the Governmental Council and the Chamber of Deputies' Commission for Health and Social Security were officially informed about the pension reform proposals on 15 January 2010 and 4 March 2010 respectively. [24]

Both, the Union of Luxembourg Enterprises (UEL) and the Chamber of Employees (CSL) commented on the working group report and the viability of the pension system in general.

The preferred strategies of the Union of Luxembourg Enterprises (UEL) consists of reducing the replacement rate of the pensions, extending the contributable period by postponing the retirement age, and financially incentivising the combination of a part-time pension with a reduced remunerated activity. The employers further propose to enlarge second and third tier pension plans, to reduce the contribution percentage and to abolish the indexation of pensions to wage development. However, they clearly profess their commitment to a pension system based on solidarity and redistribution towards the poor.[25]

In its reflection report on the long-term viability of the pension system, the Chamber of Employees (CSL) opposes all proposals concerning the reduction of the replacement rate, the abolition of pension indexation or the early retirement measure, as well as the change towards a more capitalised pension system. Instead, it sees room for increasing the pension fund revenues by increasing the labour market participation of women and older workers, abolishing the upper threshold of the contributable income, levying income tax and introducing added value as a contributable base for employers. [26]

These extreme positions brought the spring 2010 meeting of the permanently established "tripartite committee", the very strong extra-parliamentary concertation body for labour, employment and social issues[27], for the first time to fail. It contributed to a real crisis of government coalition, which was finally remedied by the Prime Minister's State of the Union speech on 5 May 2010. In consequence, a far-reaching pension reform was not upheld, and the proposals to be reduced to a reduction of the bi-annual wage adjustment and its distribution over two years.[28]

Right before the economic crisis, Luxembourg reported an average employment growth of 3.7% in the period from 1996 to 2006.[29] The employment expansion has benefited foreigners,

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[21] IGSS 2009, 86-87.

[22] European Communities, 2009.

[23] Goverment of the Grand-Duchy of Luxembourg, July 2009, 122-125.

[24] Source: IGSS.

[25] UEL 2009, 9-24.

[26] Chambre des salariés luxembourgeois 2010, pp. 21-55, See also : Feist, 19 February 2010.

[27] The tripartite committee is composed of representatives of government, employers' organisations and trade unions, It normally allows well-conciliated negotiations in order to endorse the government in taking measures to stimulate economic growth and guarantee full employment. In the same light, however, it clearly limits the government's decision-making power, as the parties can barely reach consensus among themselves in favour of strong reforms. Hohmann 2010.

[28] Prime Minister's State of the Union speech on 5 May 2010. (www.wort.lu, accessed on 5 May 2010).

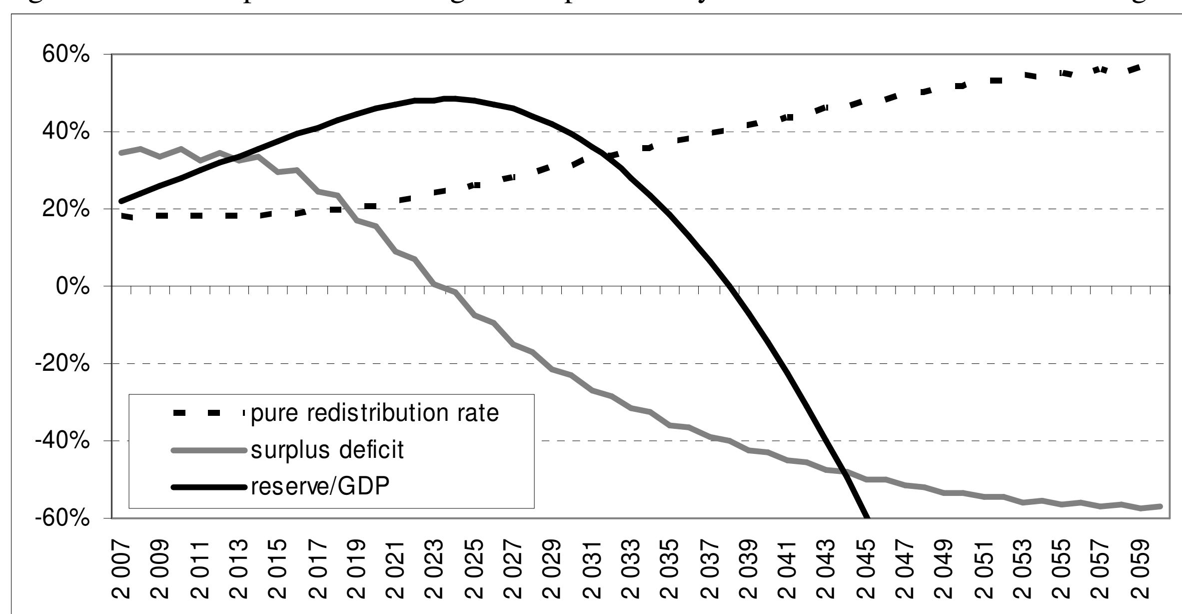
[29] OECD 2008, 25.

in particular, whose number has increased in the above-mentioned period by nearly 50%, but also brought across some spatial negative labour effects such as low employment rates among Luxembourg's elderly people and young professionals. Today, 42% of people employed in Luxembourg commute from surrounding countries each day.[30]

The last year's projections mentioned follow a methodology defined by AWG. The new scenario now derives from a 2060 horizon based on assumptions of average workforce growth of around 0.5% of productivity (1.7%) and of the economy in general (2.2%) between the period from 2020 to 2060. Concerning demography, the long-term fertility rate is set at 1.7% according to Eurostat EUROPOP2008 projections, and long-term net migration at 2800 persons per year. The projections show that despite an initial retirement wave in 2020, the system will continue allocating surpluses to the reserve until 2025.[31] From that point, the deficit will rise continuously. Limited to customary remedies, this endeavour appears to be unrealistic:

- Increase in contributions: as a single countermeasure (pure redistribution) it will rise constantly up to 60% by 2060.
- Increase of employment by an annual 2.6%, which will amount to nearly 1 million non-resident workers as opposed to 250,000 residents by 2060. Higher productivity could still partly replace this impossible growth in labour.

Figure 2: Development of the general pension system in the medium and long run



Source: IGSS 2009.

With the aim of maintaining financial viability even in a 50-year perspective, the experts went through some scenarios by applying a simplified case model developed by OECD.[32] It was based on a typical average employee with a 40-year career starting at the age of 20.[33]

[30] OECD 2010, 64.

[31] IGSS 2009, 53.

[32] QUEISSER, M. and Whitehouse, E., 2006 Neutral or Fair? Actuarial Concepts and Pension-System Design, OECD 2009. Pension at a glance 2009.

The basic scenario result for pensioners is a gross replacement rate of 89% and requires employment growth of 2.35%. However, such a long average career will become more and more unlikely and does not sufficiently consider demographic changes. Thus, three alternative scenarios have been added for comparison purposes, one with a 35-year career starting at the age of 25 (resulting in a required employment growth of 2.5% to maintain the financial balance), another with a 40-year career, entering working life at 25 and exiting at 65, which brings the required employment growth to 2%, and a last hypothetical 45-year career, resulting in required employment growth of 2%. The variation in the replacement rate among the scenarios results from the current pension formula calculated according to the pension period.

Table 1: Case model scenarios: performance of the pension system in the case of three different pension careers

	Scenario	Starting age	Retirement age	Years of contribution	Contribution rate	Replacement rate	Necessary annual increase in employment
Contributable pension periods	1	20	60	40	24	89	2.35
	2	25	60	35	24	78	2.5
	3	25	65	40	24	90	2.0
	4	20	65	45	24	102	1.8

Source: Calculations IGSS 2009.

The model highlights the positive effects related to measures that, as a first step, purely aim at the extension of working years, and thus critically scrutinises the discussion on early retirement. It also shows that, given the same contributable period, the pension system gains more from a later exit from employment (scenario 3) than from an early entry (scenario 1).

In addition, substantial reflection is also required with regard to three additional major obstacles:

1) Change of demographic pattern of the system:

   Today's beneficial high percentage of relatively young workers will logically result in a growing number of pensioners in future. IGSS expects that this growing volume of expenses will take effect in the 2020s and from then on will gradually diminish the system's financial stability.

2) The generous pension benefits:

   As the level of pensions is based to a far greater extent on total lifetime earnings than on the number of contributing years (which matters in particular for minimum pension qualification purposes), the relatively high level of wages does result in a generous pension. In addition, no regulatory parameter is currently foreseen to correctively regulate the financial risks of the lengthening of retirement periods due to higher life expectancy.

[33] At an aggregated level, the model reproduces the results of the highly developed actuarial calculations of the Ageing Working Group of the EU Economic Policy Committee. The model is based on a capitalised pension system and assumes an annual interest yield of 4.35% which, in a pay-as-you-go system, implies a yearly increase equal to 4.35%, to be hypothetically ensured by an annual increase in productivity of 2% combined with an increase in employment, which in this case needs to be 2.35%.

3) Public finances under pressure:

   Costs associated with the ageing of the population will also put pressure on the sustainability of public finances of the Grand Duchy of Luxembourg.[34] In case increased contributions are necessary, it remains questionable whether the government is able to enlarge its already considerable financial participation proportionally. The ageing population will create not only a new burden for the pension system, but also result in significant rises in expenditure for health and nursing care, both also depending on public co-funding. The weight of these expenditures in GDP is estimated to rise from 19.9% in 2010 period to 38% in 2060.[35]

Due to the crisis, these challenges are further exacerbated by the new phenomena of rising unemployment, which showed an increase of 17% between February 2009 and March 2010.[36] This structural slowdown will ultimately drain the level of reserves earlier than expected.

In its 2008 projections, IGSS simulated two different scenarios to either increase the contributions or reduce the benefits:

a) Increase in contribution rate to 33% (with 35 years of productive labour market participation): without changing the pension formula, the replacement rate remains equal to the basic scenario A at 78%, but reduces the annual employment growth necessary to balance the system by 1% (to 1.5%).

b) Change of pension formula resulting in a reduction of the replacement rate to 57%. As a consequence, the necessary annual employment growth will fall to 0.5%. However, scenario B allows the current contribution level to be retained:

Table 2: Case model scenarios: Impact on replacement rate and required employment growth in case of a set contribution rate of 33% and annual employment growth of 0.5%.

	Scenario	Starting age	Retirement age	Years of contribution	Contribution rate	Replacement rate	Necessary annual increase of employment
Pension periods	Basic A	25	60	35	24	78	2.5
	Basic B	25	65	40	24	90	2.0
Fixed contribution	A	25	60	35	33	78	1.5
Fixed replacement rate	B	25	65	40	24	57	0.5

Source: IGSS 2009.

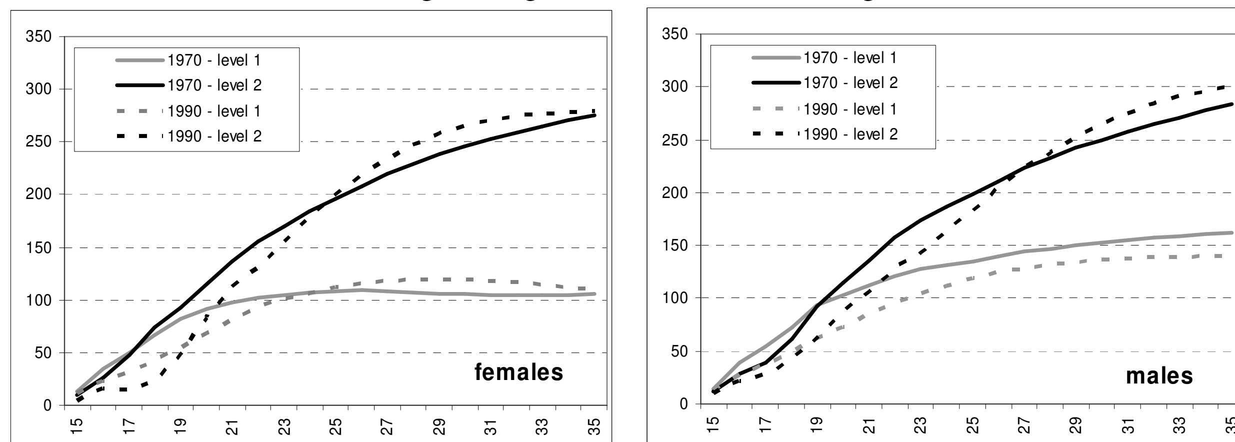
[34] The Council of the European Union in its Opinion on the updated Stability Programme for Luxembourg has pointed to the danger for the public finances in view of the long-term budgetary impact of ageing, against which no measure has been taken so far (Council of the European Union, 7329/09, point 8), MF 2010, 22-24.

[35] MF 2010– 11th update of the Luxembourg Stability and Growth pact, 22.

[36] ADEM 3/2010.

Whichever reform measure is taken, it should firstly aim at preserving the living standards of people with lower incomes. They are more likely to have linear careers while those in high-wage careers show significant progression during their careers.[37]

Graph 3: Evolution of income (in % of minimum wage) during the career, by income level (level 1: average income <2 times the minimum wage, level 2: average income> = 2 times the minimum wage) and gender for cohorts who began work in 1970 and 1990



Source: IGSS 2009.

Therefore the authors recommended implementing a reference replacement rate, which is adapted to linear low-income careers. Those insured with progressive careers can slowly become habituated to adding other pension products to their statutory pension (occupational pension, private insurance plan, real estate). Orientation in this direction is already given by some other countries (Netherlands, Sweden) where such reference rates are provided for career types, which are well known by all stakeholders in advance. Those insured opting for early retirement will then have to accept a lower pension level and others will be rewarded for staying longer at work.

Age of retirement and life expectancy

Several analyses (OCED 2010, Statec 2007, IGSS 2005) underscore the huge gap between the effective and official retirement age (65 years) and show Luxembourg, at 59.2 years for men, at the bottom end of the OECD in the period 2002-2007.[38] According to data from the latest available Labour Force Survey of 2006, roughly 25% of male and about 10% of female residents have already gone into retirement at the age of 57. Considering early retirement pensions before the age of 60, to begin with, it appears that 60% of men and women are early retirees.[39] The fact that 35% of manual workers but only 10% of highly qualified employees

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[37] The strong growth in the tertiary sector has also led to a change of educational level of the labour force. While university graduates accounted for only 15% among immigrants living in the Grand Duchy for over twenty years, their share reached nearly 45% for those who arrived during the last 5 years. Correspondingly, the weight of employees from primary education is decreasing dramatically. By comparing the educational level of immigrants upon arrival in Luxembourg in 2004/2005, the Statec labour force study of 2006 shows that about 50% hold a university degree against 28% of those from ten years before. The percentage of those with primary education dropped from 31% to 13% during the same period.

[38] http://www.oecd.org/dataoecd/3/1/39371913.xls, Luxembourg (women): 60.3; OECD average: 63.5 (men) and 62.3 (women).

[39] Genevois 2010,1. The Labour Force Survey is a non periodical special statistical analysis undertaken by Statec.

take early retirement demonstrates the significance of education with regard to the lack of contributable periods to qualify for an early labour market exit before the age of 60.

However, a closer look at the national statistics demonstrates that the changes in the employment rate of the elderly also differ according to education and population groups:[40] Older female nationals show an employment rate of 22.4% (2006), which has constantly increased over the years, whereas the rate for male nationals (34% in 2006) remains more or less stable. Foreign employees (42.2% in 2006) become more dominant among the older workforce. Here, 48% of men and 37.6% of women in the 55-64 year-old age-group were still active in the labour market in 2006.[41] Foreigners and women are less likely to have acquired enough pension years to leave the job market before the age of 65. Furthermore, different careers in different countries result in a much lower replacement level for foreigners. Additional years really help them to upgrade their pensions.

Career interruptions (excluding baby-years) of new retirees from the general pension system between 2000 and 2005 are more prominent among women than among men.[42] Women have more than 13 years interruption on average in the old age pension at age 65. In the case of men, even with an old-age pension age of 65, the interruptions are marginal.[43]

Several incentives aimed at the voluntary extension of professional careers, which were introduced by the 2002 pension reform, have not shown the expected results.[44] The incentive of an additional increase of 0.01% of the accrual rate for every year between the age of 55 and the final age of retirement is not of sufficient economic interest to stimulate postponement of the exit from employment after full pension rights have been accumulated. Similarly, as additional earnings during *part-time* early retirement lead to implicit taxation, such as direct reduction of the pension (or its suspension for the self-employed) as soon as they exceed one-third of the minimum wage, the measure is also very little used.[45]

The comparison with the reported slight decrease in the employment rate of the elderly (between 55 and 64) from 33.2% in 2006 to 32% in 2007[46] might be seen as confirmation of the unattractiveness of remaining in employment.

Another topic to be mentioned here is the effort undertaken on how to share acquired pension rights in the event of divorce. Draft legislation is under consideration on how to split the pension rights of couples, accumulated during their marriage, in the event of divorce, which is not the case in Luxembourg as yet (bill no. 5155, Art. 266)[47]. The Government Council is currently being asked to give its opinion on the amendment made by the judicial commission of the Chamber of Deputies.[48]

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40 Statec Labour Force Survey 2006, 9.

41 Lejealle 2008, 2.

42 Lejealle 2008, 7.

43 IGSS 2009, 75.

44 Beneficiaries of an early retirement pension may continue to engage in a salaried activity as long as the income earned over one calendar year does not exceed one-third of the minimum wage. Otherwise, the additional income will reduce the pension according to the anti-cumulation provision of Article 226 CSS. In contrast, revenues of an independent or self-employed activity will be deducted from the pension in full (Art. 184 CSS). For survivors' pensions the anti-cumulation provisions are less strict and lead to partial reduction when the total income exceeds EUR 2,500 (Art. 229 CSS). Between 2000 and 2005 only 13% of survivors' pensions are reduced for surviving women and 3% for men. IGSS 2009, 78; NSR 2008, 47.

45 AXA 2008, 15. Only 4-5% of pensioners pursue an additional paid activity. Among the active, more than 50% intend to continue a remunerated activity after entering retirement. See also: OECD 2010, 91-92.

46 NSR 2008, 23, Indicator OC-10.

47 Bodson and Segura 2010, 13-16. see also: www.chd.lu.

48 MSS 2010, 32-33.

Privately managed pension provision

The privately managed pension system differentiates between a supplementary pension scheme (second tier), established by private undertakings for a certain category of employees, and private pension plans (third tier) offered on an individual basis by financial institutions.[49]

The legal framework of the law of 8 June 1999 puts the various company-based supplementary pension regimes on an equal footing with regard to internal and external financing and tax provisions. It also stipulates the rights of entitled claimants. The individual employment contract needs to specify the nature of the entitlements (retirement, death, survival or invalidity). In case of a change of company, the vested rights can be transferred either to a supplementary pension scheme or to a duly approved external scheme. Certain conditions further allow repurchasing of the vested rights, such as leaving the company for a foreign country if aged 50 or over at the time of leaving, or if the entitlements to annuities or capital remain below a defined threshold. Companies are obliged to be covered by insolvency insurance or a pension security fund in order to guarantee the vested rights of the pension fund members. Contributions for supplementary pension benefits stem from taxed income, and hence pensions are not subject to taxation. Personal contributions by the employee, if any, are deductible up to an annual amount of EUR 1,200.

Private pension plans are offered as financial products to individuals. They are governed by Art. 111bis of the Income Tax Law of 11 December 2002 and the Grand-Ducal regulation of 25 July 2002. They enable everyone to take out complementary pension provision to supplement the state pension system, and allow tax deduction on an amount of income between EUR 1,500 und EUR 3,200 per year depending on the age of the policy holder. Benefits are paid from the age of 60 at the earliest. The beneficiary can opt to receive up to a 50% share of the accumulated savings as a lump-sum capital payment. The remaining part is paid in the form of an annuity. 50% of both capital and annuity benefits are taxable at the time of their receipt. The tax concessions offered for private pension plans are by far the major incentive to join, and thus to supplement the public pension. However, the public system is neither subject to any restrictions nor has it declined in efficiency; privately managed pensions have neither become very popular nor are they considered financially substantial.

Unfortunately, official statistics are not published for any of the privately managed schemes. However, in its press release for 2009, the Luxembourg insurance supervision (Commissariat aux Assurance) reports a total of around 44,288 contracts (an increase of 3.8% compared to 2008) under the private pension plan with provisions of roughly EUR 395 million.[50] Comparing the new investments for 2008 of around EUR 58 million with the overall contributory amount of EUR 3,747 billion in 2008 for all tiers together,[51] it concludes that this type of pension insurance represents only 1.54% of the total amount invested into pensions. Kneip (2008) reports 1,373 participating companies under the supplementary pension scheme in 2003, with a supplementary pension investment volume of EUR 141 million. Based on the 70% increase of companies that have registered a complementary pension plan, the estimated second tier' investment volume for 2008 amounts to EUR 240 million, which represents 6.3% of the total annual pension investment.[52]. As of the end of December 2009, IGSS registered 1,825 companies, which have established one or more supplementary pension plans.[53]

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[49] OECD 2009 (1), 234-235.

[50] Commissariat aux Assurances, 2010.

[51] www.statsecu.etat.lu, Pension Insurance, Données financières, [RG/AP/IGSS,2008] ; Kneip 2008, 5 ; Commissariat aux Assurances, 2010 ; own calculation.

[52] Kneip 2008, 5, Wictor 2009, 6, own calculation. The 2003' figures is currently the last available information on the investment volume of the second tier. However, thanks to a specially created database IGSS will be

Consequently, Luxembourg seems to have ample room to improve the information on privately managed pension schemes. An actuarial study, undertaken by Guigou, Bovat and Schiltz analyses, for Luxembourg, the sustainability of the pure PAYG pension system in comparison to a mixed system with a larger share of capitalised pension components.[54] In contrast to the high dependency of the PAYG system on demographic development, the study shows in case of a 10% saving rate for a capitalised pension plan a gain in sustainability for all income groups. The less progressive the development of income during the working career, the higher the expected sustainability gain.[55] As regards the public debate, support for reconsidering the public pension formula and giving more importance to the second and third tier can only occasionally be observed.

Property ownership is another form of private saving for old age and contributes greatly to social cohesion. In Luxembourg, a large percentage of people are private property-owners. The Figures on the risk of descending into poverty (threshold: 60% below average disposable income) related to housing status show that in 2006, such a risk is more than 3 times higher for people living in rented properties (30.3%) compared to those living in their own property (9.1%).[56]

Work incapacity

A very important impact on the rate of older people's employment is related to the disability and incapacity situation. A proportion of 15% of the active population aged 50 or above leave their professional careers because of health difficulties or work incapacity. A total of 5% find themselves back in unemployment.[57] This demonstrates the importance of prioritising the prevention of work incapacity and measures for job retention for older workers, as well as supporting measures such as rehabilitation and redeployment programmes.

As result of the redeployment policy implemented in 2002 with the objective to reduce work incapacity through professional reintegration, roughly one-third of people with partly reduced work capacity could remain in the labour market. They took advantage of the very successful internal redeployment arrangements and continued working for their previous employers. The employment fund compensates the residual salary based on the previous full-time employment.[58]

In contrast, external redeployment, implemented as an alternative measure in 2002, has not proven to be effective. It applies to people with partly reduced work capacity who are unable to continue either in the job they previously held or in another one for their previous employer, and are consigned to the job market for one year as virtually "disabled unemployed", with little or no chance of being placed again. After this most likely frustrating experience on the outer periphery of the job market, a quasi-disability period will follow. The so-called "waiting allowance" then awarded is computed in a similar way as the level of invalidity pension and will later be replaced by the old-age pension. However, these definitely non-placeable workers continue to appear in the employment statistics. The system is a matter of considerable debate.[59] Following the OECD suggestion to tighten up the conditions of exemption and make employers more accountable for involving themselves in retraining and

able to keep records on core information of all supplementary pension plans including financial data from mid 2010.

53 Source: IGSS.

54 Guigou, Lovat and Schiltz 2010.

55 Guigou, Lovat and Schiltz 2010, 34-36.

56 Statec 2007, 61.

57 Statec 2007, 29, Genevois et al. 2005, 46-48.

58 IGSS 2008.

59 IGSS 2008.

the finding of new jobs for their previous employees, the success of internal redeployment is likely to be broadened.

The disagreeable situation has brought the Government into action. An inventory of measures concerning work incapacity has been compiled, and a study has been conducted of the effectiveness of and guidance given by the legal provisions on the internal and external reclassification possibilities as well as the costs of the same. The recommendations show room for improvements in the following areas:[60]

- Length of procedures for redeployment
- Protection of persons affected by redeployment
- Standardisation of assessment of work incapacity
- Flexibility of measures undertaken and regular follow-up of recipients
- Prevention of incapacity
- Statistical monitoring procedures

At the beginning of 2008, an inter-ministerial working group was established to elaborate a reform strategy which takes into account the report's conclusions. A draft bill on the reform of this matter is in preparation, which might pass through parliament by the end of 2010.[61]

Minimum income provisions for older people

Little has changed concerning the high minimum pension conditions. With the completion of a 40-year insurance period (including voluntary and additional periods), a pension is not allowed to be below 90% of a minimum income of EUR 1,683 in 2010.[62] This actually makes the replacement rate digressive. If an individual pension amounts to less than the minimum, the pensioner gets a supplement for the missing residual. In some case the replacement rate may be even higher than 100%. The same generosity applies to everyone who has completed or exceeded the minimum number of 20 pensionable years, whereas the minimum pension level is likewise reduced by the missing years. Survivors' pensions are subject to the same minimum levels.

In 2006, 25% of women made use of the possibility to purchase missed pension years within the meaning of Article 174 of the CSS. 8% have contributed on a voluntary basis (Article 173 CSS).[63] In case of voluntary insurance coverage, the short periods are more frequent. Men's careers do not in general require such voluntary or retroactive purchase of pension rights.

In any case, the means-tested guaranteed minimum income (EUR 1,199 in 2010)[64] applies to the elderly in the same manner as for the rest of the population. In the over-60 age-group, roughly 1.2% receive supplements to fill the gap, as compared with 3% with respect to the population as a whole.[65]

In 2009, the former tax deductions allowable for employees and pensioners have been replaced, by the law of 19 December 2008 concerning direct taxes, with an annual tax credit of EUR 300 paid to every taxable person, which will enable people with little income to enjoy nominally the same advantages as high income tax payers.

[60] IGSS 2008, 78-85.
[61] MSS 2010, 33.
[62] Social parameters 2010, www.mss.public.lu.
[63] Statec 2007.
[64] A no index-related adjustment became effective since January 2009, the minimum income remained on the 2009 level (see section 2.1.1).
[65] Social parameters 2010, www.mss.public.lu. NSR 2008, 9 and 64.

As minimum income provisions for those who have not completed a full pension career are nearly as generous as minimum pension provisions, the adequacy of pensions does not pose a great challenge for Luxembourg.

However, the authors of the 2008 forecasts also query whether the unquestionable provision of a minimum pension should necessarily be maintained at the current level, which in the case of a full career with an income of less then twice the minimum wage results in a gross replacement rate of more than 100%.[66] Furthermore, many complementary (imputed) periods currently allow the acquisition of 40 countable years without any contributions during the complementary years.

2.1.2 Critical assessment of reforms, discussions and research carried out

Previous successful transformation of the country from an economy largely dependent on industrial production of coal and steel (decline in share of overall employment from 16% in 1980 to below 10% in 2008) to a centre of international financial services (30% of total employment in 2008)[67] has made Luxembourg the country with the highest per capita income in the EU. The growth of supply was made possible as large flows of migrant and cross-border workers satisfied the constantly increasing labour market.

The macroeconomic focus on fostering economic growth and employment is based on economic and financial stability and measures to control inflation. In the light of the economic and financial crisis, in 2009 after several prosperous years Luxembourg is experiencing a public budget deficit of 2.3% of GDP, which is expected to further increase in 2010 to 4.4% Social security in particular has contributed positively to the public budget for years. In the last year, the pension fund experienced an annual surplus of roughly 2% of GDP, which is vital to keep the crisis-related public budget deficit within reasonable limits.[68]

Thanks to Luxembourg's extraordinary economic growth over the previous decades and the significant share of resident foreigners and cross-border workers in domestic employment, the accumulated reserve amounted to as much as 3.56 times yearly expenditure in 2008, which equals 28% of GDP.[69] However, in the long term, the sustainability of the pension fund is anything but secured. The changing demographic profile of the system, which currently enjoys the above-mentioned high percentage of young (cross-border) workers, very generous benefit entitlements along with very high legitimate claims, and the general dependency of all social security expenditure on public co-funding[70] combine to place the pension fund system, and with it social cohesion and political stability, at high risk in the long term.

The OECD in its 2008 and 2010 Economic Surveys on Luxembourg also emphasises the generosity of the public pension system by international standards. The surveys draw attention to the very high replacement rate,[71] which in combination with increasing life

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66 IGSS 2009, 84, OECD 2010. 36.

67 OECD 2010, 67.

68 Government of the Grand-Duchy of Luxembourg, October 2009, 17.

69 At the end of 2008, the contribution to the reserve fund corresponded to 32.2% of current expenditure. The total reserve amounted to EUR 8,897 million (IGSS, Nov 2009, 208).

70 The government's financial participation amounts to 33% in the pension fund, roughly 37% for both the health insurance fund (benefits in kind) and the long-term care insurance. Additionally, maternity benefits and contributions for people below the minimum income level are fully covered by the public budget. See: www.statsecu.etat.lu. Total des contributions de l'Etat [RG/AM/IGSS, 2008], RG/A-D/IGSS, 2008], [RG/AP/IGSS, 2008].

71 The net replacement rate is about 96% in case of a median income employee, who retires after an average 40-year career at the age of 60. For male nationals with an income below twice the minimum salary it reaches as much as 107%. (IGSS 2009, 56).

expectancy will pose a major threat to the system. It should further be mentioned that given a high share of nearly 27% cross-border workers in the domestic labour market, the Eurostat projections of a future dependency ratio of 38% by 2050 is highly misleading, as these statistics do not include the cross-border workforce. As pensioners, these cross-border workers will at least partially receive benefits from Luxembourg's pension system and will have to be added.

In its conclusions, the 2008' OECD survey highlighted the potential remedies to cope with the burning issues of the pension system in the long run, which are absolutely in line with the current national debate:

- Further increasing the system's pre-funding to keep the system stable in the light of a forty-year horizon instead of the current seven-year approach.
- Raising the effective retirement age by first bringing early retirement to an end and thus enlarging the financial base.
- Lowering the replacement rate over a long horizon to both reduce expenditure and allow the population to adjust their saving patterns.

Despite the fact that the concept of flexicurity is only slowly developing in Luxembourg, many prerequisites of the social system have long been in place: compulsory membership of the social security scheme grants people the same benefit entitlements irrespective of the nature of their contract of employment and manages to avoid penalising people with interrupted careers and other insecurities.[72] Thus, self-employed people not only have equal access to the same public health and pension funds, but affiliation is also mandatory and the government contributes to their individual pension at the same percentage as for employees (8%). The pension fund contribution for very low professional earnings is only computed for one third of the minimum wage[73], relevant in the start-up phase[74]. Also, entitlements to unemployment benefits are extended for up to two years provided that the recipient has been affiliated to the social security system for a minimum of 30 years. And the National Solidarity Fund continues pension contributions for older workers receiving social assistance if they have been affiliated for at least 25 contributable years.

In contrast, the generous social security and social aid benefits for employees reduce the flexibility of the unemployed on the labour market. Several incentives, introduced by the 2002 pension reform and aimed at the voluntary extension of professional careers, have not shown the expected results. The incentive of an additional increase of 0.01% of the accrual rate for every year between the final retirement age and the age of 55 is not of sufficient economic interest to stimulate postponement of the exit from employment after full pension rights have been accumulated. Similarly, as additional earnings during *part-time* early retirement still lead to direct reduction of the pension (or its suspension, for the self-employed) as soon as they exceed one-third of the minimum wage, the measure is also very little used.

Definitely, to evaluate the financial sustainability of the pension system, regular actuarial studies need to be undertaken, based on aggregated data on the number of contributors and beneficiaries as well as average amounts of wages, contribution and pensions. Without disputing their value, they are not suitable for analysis of the impact of reform measures on,

[72] Clément 2009.
[73] Art. 180 of the Social Security Code.
[74] Even so, the self-employed only represent 5% of the total economically active population. www.statsecu.etat.lu, Personnes protégées: répartition selon les régimes (moyenne annuelle) [RG/PP/IGSS, 2008].

for example, the effectiveness, adequacy or equity of individuals' or households' net income. Here, typical case models and microdata, collected through censuses and surveys, have the advantage of allowing analyses on subgroups of households with certain attributes (age, gender, income, working time, etc.). Thus, microsimulation also helps to assess the impact and adequacy of pension policies in the long-run.

A first microsimulation research project, REDIS, started in April 2007 with the aims of analysing the coherence and redistributive effects of the Luxembourg system of social transfers (direct taxes, social contributions and social benefits in cash). The project is funded by the National Research Fund and executed by CEPS/INSTEAD and IGSS, in collaboration with the Universities of Maastricht and Liège.[75] The results of the project will help to design efficient social transfer policies in such a way that poverty traps and inequitable results are avoided. An original aspect of the project is that, as input data, it uses panel data as well as anonymised microdata coming from administrative files.

In 2009 the analytical work done within the project continued to be focused on labour supply and earnings. In particular, a discrete choice model for labour supply was developed on the basis of microsimulation. Furthermore a model was created for analysing inequality and mobility aspects of professional careers. New modules of the static microsimulation model EUROMOD are being developed in order to simulate the redistributive effects of different pension formula and of the co-payments of the health care insurance. As to Luxembourg social policy changes, the redistributive effects of the 2008 - 2009 tax and child benefits reforms were studied. The anonymised statistical income data files by individuals and fiscal households are regularly completed by new variables and new satellite files on specific aspects – for the detailed calculation of the disposable income, for example – and on pensions. In order to develop a dynamic cohort microsimulation model on pensions, the project team negotiated collaboration with the Belgian Federal Planning Bureau, so that REDIS can take advantage of the expertise of the Bureau in the microsimulation field. [76]

As the fiscal challenge of the current public pension system is extraordinary high in the long run, Luxembourg should encourage the establishment of a more diversified system of pension provision, in which private pension plans gain more importance. In this respect, the by IGSS announced improvement in information on privately managed pension schemes[77] would definitely be of great help towards gaining a distinctive picture of the pension situation as whole.

The above-mentioned debate on the report of the national pension working group demonstrates that the Government, employers associations and trade unions are seriously considering the viability of the pension system in the long term. The future mode of the financing system will determine how and to what extent the financial risks of the pension scheme need to be averted. IGSS' and the EU AWG' extensive analyses[78] make obvious that more than spontaneous action is needed. However, any implementation of necessary pension adjustments requires, first and foremost, a social consensus to be found. Therefore, the reform measures should be well designed, putting neither the competitiveness of the economy nor standards of living nor the system's public credibility at risk, and should be presented in a comprehensible way. To keep the current configuration of benefits, further continuous inflow of labour and economic growth remains vital. Therefore a future increase in the contribution rate combined with a rise in the effective retirement age could be the most probable option in the long run.

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[75] www.fnr.lu, REDIS – Coherence of Social Transfer Policies and Microsimulation.

[76] www.fnr.lu, REDIS – Coherence of Social Transfer Policies and Microsimulation.

[77] See footnote 54.

[78] IGSS 2009, European Communities 2009.

However, in the light of the still favourable demographic and financial situation, the reform options could have been even more far-reaching. A first attempt has been made by the scenario presented, with a fixed replacement rate of 57%, and others can be read between the lines, without being recommended explicitly. The financial and economic crisis showed that stakeholders who have long hesitated to engage with pension issues are now open to such a discussion. In order to agree on a moderate decision that still lays down markers for the future, options to lighten the financial legacy left for future generations may be expressed even more radically.[79] This includes limitations on the level of wage-related indexation of pensions, implementation of sanctions or bonuses for early or late retirement respectively, lowering of the replacement rate for the better-off, strengthening anti-cumulation provisions, re-considering the survivor's pension etc.

The first hurdle to overcome is to adjust the legal framework in a manner that allows planning beyond the current seven-year horizon. This should already apply for the next legal period between 2012 and 2019, so that it encompasses a more stringent rules about when retirement can be taken until at least 2030 or beyond.

However, all of the presented measures are still under consideration. In spring 2010, government and social partners are about to decide which measures will be given priority and when implementation will start. At the time of finalising this report, the final decisions were yet not released.

2.2 Health

2.2.1 Health system's characteristics and reforms

Luxembourg's health care system is characterised by the principle of universal access to a modern, comprehensive package of health services. Affiliation to the public health insurance scheme is mandatory for all economically active persons. It covers a comprehensive package of health services. Hospital infrastructure is modern and meets the latest technical standards. Patient satisfaction is high in relation to the care provided. According to a national survey from 2009, 63% of the residents interviewed think that the systems only need minor changes.[80] They enjoy free choice of doctors and have direct access to specialists. The Euro Health Consumer Index 2009 ranks Luxembourg in 8th place out of the 33 countries in the index. Especially on the indicator "range and reach of services", which covers equal access to services and cancer detection programmes, Luxembourg got above-average scores.[81] In 2008, life expectancy was 83.1 for women and 78.1 for men.[82]

Financing

In 2006, the reported total expenditure on health care (TEH) was EUR 2,461 million, representing 7.3% of GDP [83] and amounting to USD 4,162 PPP (in EUR: 3,317)[84] per insured person, which include residents and non-residents.[85] Due to the comprehensive benefit

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79 According to the AXA barometer 2007-2008 on pensions, 60% of the active population and 47% of pensioners expect a pension reform in the next 10 years, of which 70% (79% of pensioners) assume an increase in working years and 64% (52%) a reduction of pension benefits. AXA 2008, 59-60.

80 TNS-ILRES 2009, Sample size: 484.

81 Health Consumer Powerhouse 2009.

82 Source: Eurostat, Life expectancy at birth, by sex (ind HC-P4a).

83 Source: ECO-Health OECD 2009, total health expenditure as a percentage of GDP (ind HC-P12).

84 Based on an annual average exchange rate for 2006 of USD 1 = EUR 0.797.

85 Source: Eco-health, OECD 2009 total health expenditure per head of population in PPP (ind HC-P11). The non-residents represent 30% of the total number of insured people.

package of the mandatory social health insurance system as well as the Government's huge investment in the health infrastructure, the public expenditure share of TEH amounts to 90.9% in 2006, the highest in Europe. Private expenditure accounts for 9.1% of TEH, including out-of-pocket payments and private insurance that only represents 1.7% of TEH.[86]

Health Insurance

The public health insurance system is compulsory for all persons participating in the Luxembourg economy as employed, self-employed or recipients of replacement benefits (sickness, maternity and unemployment, invalidity, old-age and survivors' pensions, guaranteed minimum wage, etc.). In addition, derived rights are granted to non-insured family members. In sum, the system covers 96% of the resident population[87] and 203,100 non-resident people (= 30% of the total insured population!) are affiliated as cross-border workers (or their family members).[88] The cross-border population places the Luxembourg social security system in a favourable demographic situation. This population is nine years younger, on average, and includes only 0.2% of people over the age of 65 years.[89]

The state not only makes substantial direct contributions to health insurance (38% for benefits in kind), maternity (100%) and the long-term care insurance system (around 40%), but also pays the health insurance contributions for students and children without direct affiliation rights as well as for people below the minimum guaranteed income.[90]

Despite the limited scope of private and supplementary mutual health insurance benefits, which contain only supplementary coverage for the co-payment of the public scheme and certain first-class medicine services in hospitals, nearly 50% of CNS[91] members opted for it, with a huge preference for the Caisse Médicaux-Chirurgicale Mutualiste (CMCM), the mutual health insurance association for supplementary health coverage.[92] In 2010, CMCM launched a new supplementary insurance product to cover part of the costs for dentistry and ophthalmology services.[93]

Health insurance is organised as a reimbursement scheme for members' expenses for a large variety of health benefits with an estimated average reimbursement rate of 91.8%. Only hospital care is offered as a benefit in kind, with the exception of the doctors' bills, which, similar to outpatient care, have been pre-paid by the patients themselves. Despite the fact that a few new measures led to slight increases of the co-payment level (i.e. 10% instead of 5% for the first GP consultation in 2005), the total amount of out-of-pocket payments for health care amounted to 6.5% of total current health spending in 2006.[94] Even so, the reimbursement system as such tends to negatively affect low-income groups, who, as they are unable to pre-pay the health care bill, might postpone necessary health appointments in order to avoid

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86 Source: ECO-Health OECD 2009, Expenditure on health by financing agent, % of total expenditure on health, 2006 (ind HC-C3).

87 The group of the non-insured represents to a large extent EU civil servants residing in Luxembourg and affiliated to their own social security systems as well as some people covered in another Member State., IGSS 2009, 26, t.

88 Source : IGSS 2009, 26, www.statsecu.etat.lu: Population protégée (moyenne annuelle) [RG/PP/IGSS, 2008], Assurés frontaliers actifs et volontaires: répartition par groupes d'âge (moyenne annuelle) [RG/PP/IGSS, 2008])

89 www.statsecu.etat.lu.

90 www.statsecu.etat.lu: Total des contributions de l'Etat aux recettes courantes de l'assurance maladie-maternité [RG/AM/IGSS, 2008].

91 CNS = Caisse Nationale de Santé (national health fund).

92 www.cmcm.lu, Rapport de gestion de l'exercise 2009.

93 MS/MSS, 4/2009, 7-8.

94 Source: ECO-Health OECD 2009. This figure only refers to the part of the health care bills not reimbursed by health insurance, and does not include over-the-counter payments for non-refundable drugs and health commodities and private expenditure for long-term care.

stigmatisation by the health insurance scheme.[95] Financial obstacles exist in particular for dental care, where liberalisation of price setting by dentists results in high out-of-pocket contributions of up to 43% (in 2005) being incurred by households.[96]

The financial situation of the health insurance system is far from being stable. Unlike the pension fund, neither a surplus nor substantial reserves have ever been built up in the past. Thus, the health insurance system is exposed to the drawbacks of a decreasing labour market in its entirety. Thus, given the historically high employment rate and the general precarious financial situation of the health insurance fund, action on health insurance is urgently needed. Today, the most drastic issue confronting the system is that insurance revenues, similar to the pension fund, are strongly associated with GDP and the employment level, which are both in a state of collapse since October 2008.[97] Rising unemployment not only reduces the number of affiliates, but notably also the number of cross-border workers, who for reasons of age structure and a preference to use their own systems of care, where costs are mostly cheaper. Estimates show that equal spending by non-residents would result in total health expenditure 15% higher.[98] Such impacts need to be taken into account for further forecasts.

To date, the health insurance scheme has little discretion to influence the volume of services. Fee-for-service is still the predominant payment system for medical services, and is also applied in hospitals for doctors' remuneration, independent of the hospitals' budget-based payment.

A particular cause for alarm are Figures showing 3.4% higher health care spending growth versus real GDP growth in the favourable period between 1998 and 2008 and almost 6% annually in real terms.[99] For 2008, IGSS reports an increase in health spending of 5.4% and expects another increase for 2009, again exceeding 6%.[100] Expenses for investments in hospital infrastructure are largely financed through the state's hospital investment fund (80%), governed by the Ministry of Health, and only require 20% of co-funding on behalf of the health insurance scheme. In the event of delays however, the latter is threatened with substantial charges on all running and maintenance costs of the new infrastructure. Unfortunately, such long-term costs are not or not sufficiently subjected to cost efficiency analyses prior to investment decisions.

The share of cross-border health services is becoming more and more important.[101] In 2008, the expenses for foreign health care services amounted to nearly 17% of the total health

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[95] TNS-Ilres 2009, C.N.E. 2007, 63-90. The offered fast-track reimbursement or pre-payment can not fully relativise the stigmatisation problem.

[96] OECD 2008, 12.

[97] Feist, 16.01.09.

[98] OECD 2008, 108.

[99] MSS 2010, 22. This might partly be explained by the annual 3% increase in the population covered during the same period, of which 0.6% were pensioners, and partly by important investments in the modernisation of health care infrastructure and health technology during this period. Marx, 3 March 2009, reported an investment volume of EUR 700 million in the years 1998-2008 and prospects of another EUR 500 million for the next 10 years.

[100] IGSS November 2009, 87.

[101] As the geographical and financial centre of a the so-called Greater Region, a synthetic area composed of the Grand Duchy of Luxembourg and surrounding regions of Lorraine in France, Saarland and Rhineland-Palatinate in Germany and the Belgian Provinces of Luxembourg and the Belgian German-speaking areas, its international importance should not be underestimated. 11 million inhabitants live in this "Greater Region", but the mobility of employees and consumers is nowhere near as high as in the direct surroundings of Luxembourg. Luxembourg accounts for 150,000 cross-border workers, who reside in one of the neighbouring countries. It includes a substantial number of doctors, nurses and other professionals employed in the domestic health sector. The rapidly increasing mobility of citizens makes the cross-border situation with regard to health and social security relatively complex.

insurance expenditure and rose by 9.2% in relation to the year 2007.[102] This peak not only reflects the significant number of cross-border workers among the insured population, but also confirms that Luxembourg has fully implemented the ECJ rulings on the European Regulation on the coordination of social security systems (1408/71 EEC – since 1 May 2010 replaced by the Regulation 883/2004 EC). Today, only 1% of the required pre-authorisations for cross-border health care are refused by the CNS.[103]

Uniform social security status

As of 1 January 2009 and caused by the implementation of the uniform social security status for all private sector employees, five of the former health insurance funds merged into the national health insurance fund (Caisse Nationale de Santé, CNS). The reform brought equal rights for the previously identified groups of manual workers and other employees under labour and social legislation and thus resulted in far-reaching structural changes to the social security system. [104] As a result, social security contributions and benefits were harmonised; this is of particular importance for continued payment of wages during short term sickness leave. Also, the two groups' respective fund (sickness, pension), their representative chambers and social tribunals merged. This equally affected the composition of the corporatist bodies.[105] Furthermore, the new "Social Security Code" legislation replaced the former "Social Insurance Code". Only civil servants have kept their separate social security system.

With regard to benefits, the uniform status has a particular impact on continued payment of wages during sickness leave. In such event, the employer will now continue to pay wages for up to 13 weeks per 12-month period. The associated excessive financial burden on employers with respect to manual workers has been buffered by some transitional provisions and the creation of a new employers' mutual insurance fund to cover the risk of their sick pay obligations.[106]

The contributions for the new employers' mutual insurance fund have to be borne only by the employer. Its rate is set at four different levels (0.35 to 2.29% of accumulated gross wages) depending on the volume of insured risk and the sickness rate of the covered employees. Membership is, in general, mandatory. The self-employed can affiliate on a voluntary basis. Since checks of work incapacity were strengthened in parallel for both employers and the Social Security Medical Inspectorate, IGSS started to monitor the impact on future work absenteeism. In a recent study, the 2009' rate of work absenteeism (estimated on the date of the first 9 months) was compared to previous years. It surprisingly releaved that as well the total rate of 3.2% as the rates for manual workers (4.4%) and for employees (2.3%) remained nearly stable over the last four years. [107]

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[102] IGSS November 2009, 87.

[103] Source: CNS.

[104] European Commission, note 485/08. Following a 2006 agreement between the Luxembourg government and social partners, the new arrangement entered into force on 1 January 2009 by means of the Act of 13 May 2008.

[105] The results of the social elections in November 2008 decide for the next 5 years on the composition of trade union representatives in the chamber of employees and all professional chambers.

[106] As a transitional provision for a period of three years, manual workers are compelled to carry on paying higher social security contributions than employees, which were formerly justified by the health insurance system's obligation to provide continued wage payment. The employers will be compensated by this residual. However, the workers' supplementary contribution will be gradually reduced until, by 2012, an equal contributions level of 12.35% applies for all employees, to be borne in equal shares by employers and employees.

[107] MSS/MS 1/2010, 9-11.

With regard to health, the new uniform status has not brought about any substantial changes to the health care system, but benefits in cash (i.e. sickness pay) have been affected to a much larger extent. Overall, it has contributed to greater efficiency and enhanced management capacity of social security matters, and has been of particular benefit to companies, which are no longer obliged to manage the two categories of employees separately. However, it also challenged the new health fund by necessitating an enormous administrative reorganisation.[108]

Health Care Services

The system offers health services at all levels but is, however, strongly orientated towards hospital care. In 2008, 50% of the expenses of health insurance were spent on hospitals, which due to some accounting rules do not include the doctors' fees in hospital. If these costs were added to the hospital expenses, the share of hospital expenses would rise even more.[109]

According to the hospital law of 28 August 1998 and the latest national hospital plan of 13 March 2009, the sector is divided into three geographical areas and counts for 2,312 acute beds[110] in five general hospitals and six specialised institutions (including some centres of excellence). Due to the lack of strong coordination between outpatient health services, hospital, rehabilitation and nursing home centres as well as preventive health services, the planning of health care services remains fragmented and faces difficulties in anticipating service requirements on local, regional and national levels with respect to future trends such as ambulatory surgery or demographic changes in society.[111] The pharmaceutical sector is regulated in a similar way as the hospital sector. The number of pharmacies is limited to 1 per 5,000 inhabitants.[112] In its 2010 report, the OECD largely criticises this restriction.[113]

With the exception of one hospital (Centre Hospitalier de Luxembourg), all hospital doctors work as self-employed attending doctors and are remunerated separately from the hospital according to the tariffs stipulated in the nomenclature for medical acts. The latest tariffs markup (lettre-clé) came into force on 1 March 2009. In 2007, the average annual gross income (after deduction of expenses) of general practitioners is reported at EUR 123,515 and that of specialists at EUR 251,741 with radiologists, neurosurgeons, nephrologists, cardiologists and anaesthetists at peak.[114] The system does not provide for recovering any rental charges from doctors for the use of hospital equipment or support staff.

All health care providers must be approved by the Ministry of Health. Authorisation is given according to the appropriate level of medical and language competence, controlled by the Medical College. The authorisation is linked to a convention with the CNS stipulating the remuneration fees for treatment for CNS patients.[115] The convention is associated with the absolute freedom of each doctor to decide on whatever treatment he considers necessary without any obligation concerning its economic impact. This freedom was long unimpeachable, and has now cautiously been called into question.[116] In the period from 2004

108 MS/MSS, 1/2009, 8-9.
109 IGSS November 2009, 86.
110 It represents 4.8 beds per 1,000 inhabitants on January 1, 2008. Sources: Règlement grand-ducal du 13 mars 2009 – Plan Hospitalier, www.statsecu.etat.lu , Eurostat.
111 Feist, 16.01.09.
112 Consbruck 2009, 10.
113 OECD 2010, 48-50.
114 IGSS November 2009, 74-75, Feist, 20 March 2009.
115 Consbruck 2009, 4.
116 AMMD, Bulletin special 2010, In 2009, the CES proposed to add a number of framework conditions to the convention to allow the health insurance fund some form of control over the number of practicing doctors, the quality in terms of minimum requirements for continuous training, medical documentation and the respect of the most economic medication, where scientific evidence for equal output against more expensive medication is given. CES 2009, 58-61.

to 2008, the number of doctors rose by 25%. The population, in contrast, only grew by 6% and the protected population by 12% over the same period.[117]

Prevention

The Economic and Social Council (CES) argues in its 2009 report that for a long time the Luxembourg health care system has largely been concentrated on cure, and proposes to change that focus. Most chronic diseases, including cancer, heart disease and diabetes are largely preventable, and can in theory be avoided if people take more responsibility for their own lifestyles. As treatment is expensive, the Council encourages strengthening prevention as the more cost-effective route for the health care system. [118]

In the past two years the number of prevention programmes has increased rapidly, and several of these programmes only started in 2008.[119] Cancer detection programmes, in particular, (mammography, colonoscopy, prostate examination) have run for longer and are showing positive results.[120]

Whereas the OECD criticises Luxembourg's comparably low spending on preventive care (only 0.8% of public expenditure for health),[121] national actors and authorities suggest reading these OECD data very carefully. In fact, based on a national calculation, in 2005 Luxembourg spent 10 EUR per insured for prevention. Compared to the German figure of 2.74 EUR per insured, the low Luxembourg rating is somewhat astonishing[122]. Apart from the calculation method of the index, an explanation might also be found in the national division of competences between the health directorate and the health insurance system as well as the absence of a clear standard of what has to be recorded as preventive care by these two institutions.[123] Quite a number of effective preventive measure that are undertaken are not defined as such statistically: routine medical and dental examinations, colonoscopies, etc.

eHealth

The government launched a new strategic e-health plan in November 2008 as part of the European action plan "i2010". The plan aims to make the health sector more dynamic in the exchange of medical data and in coordinated action in investments in technology for Information and Communication Technology (ICT). It also foresees the introduction of an electronic health card. The technical development of the eHealth strategy is to a large extent subcontracted to the public research centre CRP Henri Tudor (www.santec.lu).[124] It consists of the following components:[125]

- The **Portail Santé (Health Portal)** (www.sante.public.lu) was launched in 2009 and contains relevant information in the field of health care for the general public and professionals.[126]
- **eSanté –EFES (Feasibility)** analyses the current use and status of e-applications by health care providers as well as requirements and sector priorities. So far, the EFES

117 IGSS 2009, 26 and 70.
118 CES 2009, 6 and 55.
119 Detection of congenital anomalies, withdrawal of tobacco dependency, vaccination against human papilloma virus, a prevention centre for back exercises, promotion of healthy nutrition and physical activity - MS 2009, MS/MSS 2008.
120 MS 2009, 35-43.
121 OECD 2008, 124.
122 MS/MSS 2/2009, 1-2.
123 Becker 2009, 49-55.
124 www.santec.lu.
125 MS/MSS 1/2010, 12-14. See also: www.santec.lu.
126 See also the section on health information.

team has conducted an inventory of the different software systems used by the hospitals and specialised national health centres, an inquiry on the use of electronic administrative and diagnostic services by medical doctors, nurses, other health personnel and by and within hospitals. The findings show the lowest penetration rate in nursing homes, whereas in hospitals and laboratories, the use of electronic applications has become a daily routine. Finally, EFES scrutinises the technical data protection requirements for a safe national eHealth platform, consisting of patients' identifiers, secure log-in, trusted third party and pseudo-anonymisation of electronic health information.

- **eSanté–CARA** aims at building up an electronic registry of imaging methods and techniques in order to allow electronic access to existing images and thus avoid unnecessary duplication of investigation. In the end it will lead to both a more economic use of resources and a reduced exposure to radiation for patients.
- **eSanté-LABO** plans for an online recording system of lab results and should allow access and exchange by different hospital and ambulant lab services. A unified national application of the international codification LOINC is an important prerequisite for this project.

Health Information

In April 2009, the Health Portal (www.sante.lu) went online. It intends to promote healthy living and preventive actions, and provide better orientation in the health sector. Developed by the government institution e-Luxembourg and the research centre CRP-Santé, the Health Portal brings together all information about health on one website for both, citizens and professionals. It provides information for prevention, background information and fact sheets on diseases, and the payment rules and procedures of care consumption. Furthermore, an overview of all actors of the Luxembourg health care system, relevant legal provisions as well as publications and main events can be found. In the course of the year 2010, a directory of all health services in Luxembourg will be added.[127]

The range of media is completed by the online-newsletter "Insight SantéSécu" of the Ministries of Health and Social Security, which has, since 2006, issued information 3-4 times a year about the latest developments in the sector. It is distributed to the main health actors and interested subscribers, but also available on the website of both ministries.

Coordination

As the main coordinating mechanism, the quadripartite committee, composed of representatives of employers' associations, trade unions, the health care providers and the Ministries of Health, Social Security and Finances, carries out a bi-annual review of the efficiency of the measures in place with regard to the quality of performance of the health care system and the financial balance of the health insurance scheme. If necessary, new directions can be proposed. By virtue of its composition, the quadripartite committee allows a well-balanced assessment of the topics analysed, but in the same light, clearly limits its decision-making power, since the parties can barely reach consensus among themselves in favour of strong reforms; strong voting rules have not been established, nor do its recommendations have binding effect. It mainly fosters the government's accountability for the measures taken.

[127] www.sante.public.lu.

2.2.2 Debate on the 2010 health reform

The governmental programme 2009-2014 envisages a structural reform for the health care sector in order to gain more transparency, more efficiency but also cost containment and financial stability. At the quadripartite meeting[128] in October 2009, the Government, social partners and health care providers agreed on a "stability pact", prioritising among other things economic measures through a better organisation of health care to a potential increase of health insurance contributions or co-payments.[129] The agreement aimed at sensitising all partners, government administrations, providers and consumers of health care for sharing the responsibility for making the pact successful.

As an immediate measure of this pact, by means of Art. 53 of the law of 18 December 2009 on the public budget 2010, the Government has reduced the minimum reserve to 5.5% in 2010 from its usual level of 10% as stipulated in Art. 28 No.1 of the CSS. This made it possible to cover the expected deficits of EUR 92.5 million without any increase in the contribution rate. It also authorises the health insurance fund to request a loan from the long-term care insurance fund if necessary.[130] In the short run, this measure relieves any immediate additional financial burden on employers and employees, which would also bring the public budget under additional pressure, from which a substantial part of the additional contributions will have to be paid. However, without additional reforms, it only postpones such inevitable and painful financial consequences.

Therefore, in the same months of the quadripartite meeting, several inter-ministerial working groups were established to propose feasible reform strategies for a short and mid-term perspective, which later reconciled their proposals with representatives from the health care providers, the employers and the employees. The working groups came up by end of March 2010 with a variety of interesting suggestions on following subjects.[131] Not all of them were supported by all actors involved.[132]

- **Remuneration of health care providers:[133]**
  - The Luxembourg fee-for-service tariff system (nomenclature) should be revised and be built on more scientific evidence and potentially use an established foreign system as reference (the French CCAM[134] or the Swiss TARMED system). Among other aspects, it should also take into account the time to perform one medical procedure or the other, and also financially favour the pursuit of health care priorities (integrated health care concepts, ambulant surgery, etc).
  - Fee-for-service payment for medical doctors should be complemented, wherever appropriate, by salaries, tariffs by time spent and/or capitation payment.

[128] The Quadripartite is the most important extra-parliamentarian biannual coordination mechanisms between Government, social partners (employers' and employees' organisations as well as the representative bodies of the health care providers.

[129] MSS 2010, 22.

[130] MSS, 2010, 23, IGSS November 2009, p. 141 ; see also : Marx, Léon: "Umstrittener Griff in die Reserven", Tageblatt, Luxembourg, 11.11.2009.

[131] http://www.mss.public.lu/publications/divers/quadripartite_2010.pdf. See also: AMMD, No. 3 and 4/2010

[132] Feist, 18.03.2010.

[133] AMMD, 3/2010, 2-14.

[134] CCAM is the French medical classification for clinical procedures, which also serves as reimbursment classification for clinicians (Classification Commune des Actes Médicaux - CCAM).

- The functioning and composition of the commission on determining the nomenclature procedures and tariffs should be reorganised, institutionalised and also enlarged.

- **Documentation and evaluation of health care services:**[135]
  - It is intended to improve and standardise the quality of the medical documentation: for the documentation of medical procedures, the currently used nomenclature (tariff system) no longer seems appropriate and should be replaced by an internationally accepted classification of medical procedures. ICD-10 coding should be enlarged to at least four digits and should also be used for the initial diagnosis. Instead of a hospital episode it is recommended to introduce an episode by illness.
  - The implementation of a unified electronic health record is considered a supporting prerequisite to meet the quality targets of a better documentation system.

- **Coherent hospital and ambulant care development:**[136]
  - The longstanding hospital organisation with a separated institutional function of a hospital, budgeted on the performance of a care service volume, and the affiliated doctors practising within it, who are paid separately on a fee-for-service basis, is called into question. The physician gets its bill paid by the patient, who will then be reimbursed by the health insurance fund. In particular, the relationship between the hospital and the doctors and their mutual dependencies should be re-clarified to better integrate the doctors in the functioning of the hospital; also, budgets should be negotiated for a two-year period.
  - For the ambulatory sector, primary health care should be strengthened, the hospital-based polyclinic structures re-assessed, a suitable form of gate-keeping system developed and ambulant surgery should be given priority, wherever appropriate.
  - Through the creation of a national agency for health information technology, the development and interoperability of the IT software and infrastructure in both the hospital and ambulatory sector should be better coordinated.

- **Drugs and pharmacies:**[137]
  - A consensus has been reached for moving towards a system of e-prescriptions, which not only enables improvement of the quality and safety of drug prescription but also means that an economic gain can be realised.
  - In the future, prescription should be based on active ingredients in order to allow in case of the same quality of the treatment for a substitution of branded products by cheaper generics.
  - Pharmacies should be remunerated by fixed price per unit of drugs in order to avoid any penalty for selling or substituting expensive drugs with cheaper generics. For the health insurance fund, a volume-based discount on the industrial purchasing price should be settled for those drugs which are listed in the positive list.

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[135] AMMD 3/2010, 15-20.
[136] AMMD, 4/2010, 9-16.
[137] AMMD, 3/2010, 21-29.

- **Laboratories:**[138]
    - The overall supply of lab services is considered to exceed domestic needs by far, and the currently applied tariff system does not take account of the technological and efficiency gains of the last twenty years. Therefore, the recommendations aim at reorganising hospital laboratories, review the lab and improve the information and mutual use of lab results between hospital-based and private ambulatory labs through a standard-access, centralised and interoperable database.
- **Health Insurance Reforms:**[139]
    - The system of third party payment currently applied for prescription based drug purchase at pharmacies and for hospital services should gradually be extended to medical services, starting with a particular system for people in economically vulnerable situations.
    - The maternity expenditure consists of maternity services as stiputated in Art. 26 CSS and payments for salary replacement during statutory maternity leave (16 weeks) and for additional days of work incapacity during pregnancy and for taking care of the child in case of illness in early childhood. It is 100% funded by the government and administered by the health insurance system. In 2008 the total expenses amounted to EUR 141.1 million.[140] It is proposed to bring the maternity payment into the standard health insurance provision and fix the government contribution.

The final decisions on these very ambitious health care reform proposals still remain to be specified in greater detail. Equally, it will be important to assess the economic impact of the preferred measures to estimate the impact for the whole economy, the labour market and the public budget. All proposals have in common that they are intended to help keep social security contributions low while also strengthening the international competitiveness of the established health care providers. Unfortunately, the presentation given by the minister at the quadripartite meeting on 24 March 2010 was, however, considered anything but convincing. Both social partners and the associations of health care providers expressed their dissatisfaction about the lack of a reform conception, as the working group members saw their own proposals being repeated rather than conclusions drawn from them by the government.[141]

The Government is now preparing a bill on the reform of the health insurance and the organisation of the health care system. It is announced to pass through parliament in the course of 2010 and enter into force from 1 January 2011.

2.2.3 Impact assessment

Cost-containment

Appropriate cost containment measures combined with quality improvement of health care services represent the overarching goals of the Luxembourg health policy. The approach is very much focussed on improved and reliable information for policy development and decision-making. With regard to the future of the health care system many stakeholders

[138] AMMD, 4/2010, 2-8.
[139] http://www.mss.public.lu/publications/divers/quadripartite_2010.pdf.
[140] IGSS, November 2009, 122-126.
[141] Feist, 02 April 2010.

favour substantial investments in various impact studies, as previous endeavours have only shown limited success.

- A more **centralised hospital purchasing** is only organised on a voluntary basis and coordinated by a working group of the hospital association EHL, the government tried to identify in concerted action with the hospitals the most suitable areas to be logistically centralised. Central purchasing, hospital pharmacies, laboratory, sterilisation and informatics were in the focus of interest. [142] Looking into the recent reform proposals, the central coordination of IT applications by health providers seems to be given the highest priority.
- So far, proposals on reforming the **hospital payment system** have met with little success. Unaware of the limitations of medical documentation in Luxembourg, the authors of the OECD 2008 assessment on Luxembourg favoured the development of the DRG system and a performance-based payment based on clinical pathways.[143] A study commissioned in 2007 by CNS to develop strategies to modify the system of variable hospital costs excluded the bulk of costs for doctors and nursing services from the outset, and thus has shown only a marginal effect with regard to the economic gain.[144] Here, the current reform proposals put the emphasis on new form of payment mechanisms for hospital doctors.
- Since 2005, the government has tried to limit the high **volume of medical lab tests**, which was caused in part simply by the sector’s overcapacity. As negotiations on a flat-rate reimbursement failed, the number of chargeable tests per prescription was set at 12 for private laboratories. In 2007, the administrative court declared this limit discriminatory unless it is applied equally to hospitals. This consequence has again triggered the discussion on flat-rate payment, the level of tariffs and the establishment of a central database. In December 2008, the Ministry of Social Security reduced the tariffs for lab tests by 20%.[145] Cost-containment for lab expenses still remains on the agenda.
- Not only did the OECD require political and remuneration decisions to be based much more on **cost-efficiency analyses** and international benchmarks; in particular, it also mentioned the Commission for Nomenclature and the introduction of a gate-keeper system as well as a partial replacement of the fee-for-service payment with capitation. [146] In particular, Luxembourg lacks a specialised institute of health economics that is active and highly reputed at both national and international level. This would help to bring demands for efficiency gains onto a scientifically sound basis.

Quality of health care

Luxembourg is aware of the necessity to constantly assure and improve the quality of services and procedures. The following overview presents a now exhaustive list on recent measures and studies:

- The Scientific Council, created in 2005, developed treatment guidelines for five selected areas[147] based on international scientific standards of evidence-based

[142] MS/MSS 1/2008, 13-16.
[143] OECD 2008.
[144] Unpublished study on options for variable costs in hospitals. Source of information: IGSS.
[145] Feist, 6.03.09.
[146] OECD 2008, 108.
[147] Treatment with antibiotics, laboratory analyses , vascular disorders, oncology, prescription of medical imaging.

medicine, but excludes economic evaluation.[148] As from 2009, the Luxembourg Association for continuous training for physicians (ALFORMEC) has explicitly integrated the recommendations in its syllabus.[149]

- The Center of Health Care Studies of the research centre CRP-Santé is undertaking several surveys concerning the impact of certain diseases and medical disorders on the country's socio-economic situation. Its current projects encompass cardiovascular risk factors of the population, headache (as part of Eurolight), health behaviour in school-age children, obesity and excess weight in children, and impact of stroke on quality of life and the family)[150]
- Since 2003, EFQM has been used as standard measure for quality assurance in hospitals[151] and is being promoted through a financial incentive to upgrade the overall hospital budget by an additional 2%. In 2008, a survey of hospital patients' satisfaction has been commissioned from the Swiss Picker Institute. The high number of returns of nearly 50% demonstrates the importance of the subject for the Luxembourg public. The findings show that Luxembourg patients assess the establishments' medical-technical care and facilities very positively, but in particular psycho-social support is found to be in need of significant improvement. As a new instrument of quality management, the patient survey has shown the perception of quality of care in a new light. Used as a permanent instrument of the quality process, its impact will be become valuable.[152]
- Health Consumer Powerhouse, a Swedish registered institution providing various health consumer-focussed indexes, ranked Luxembourg in 8th place in the 2009 index on health care systems, evaluating areas like patients' rights, patient information, eHealth, waiting time, health outcomes and reach and access to services. Whereas Luxembourg was scored above-average for the indicator "range and reach of services", which covers equal access to services and cancer detection programmes, it was negatively mentioned concerning the limited control of drug consumption, limited health information and the extent of consumer-friendly IT-applications in use. In another index, the heart index 2008, evaluating patient information, prevention, medical procedures and the results in the respective area in 29 European countries (EU Member States, Switzerland and Norway), Luxembourg was put in first place.[153]
- In 2009, IGSS launched a pilot project on quality assurance of hip and knee endoprostheses using administrative data (QSR). Based on a scientific approach developed in Germany by the AOK/Helios[154], the study analyses the administrative records of CNS. As a result, the study confirmed that the data available in Luxembourg are sufficient for a quality analysis. Age and gender-specific risk-adjustment revealed some minor differences in mortality, average length of stay and complication rates among hospitals. However, the conspicuously large incorrect and missing coding and the error-prone data processing procedures considerably limit the statistical power. As medical billing can be done by both the individual surgeon and

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148 Although bound to standard operating procedures comparable to those used for Health Technology Assessment, the Scientific Council has neither implemented a standardised reporting structure nor established any formal link to the HTA society. The impact evaluation is not yet formalised.

149 Source: Conseil Scientifique.

150 www.crp-sante.lu.

151 OECD 2008, 115.

152 MS/MSS 3/2009, 4-5.

153 Health Consumer Powerhouse 2008, MS/MSS 2/2008).

154 http://wido.de/qsr-bericht.html.

physician groups, it is impossible to identify in the administrative data the surgeon in charge. The applied method enhances the existing quality management instruments (EFQM, satisfaction surveys) with an interesting and scientifically proved tool. Despite the fact that a much better quality of documentation is required as a prerequisite to make use of it for outcome evaluation, IGSS as commissioner of the pilot study underlines the opportunity that its pilot application already allows to jointly learn from the system's own experiences and results.[155]

Competitiveness of the health industry

In 2008, Luxembourg made an important large investment of EUR 140 million spread over the following 5 years in BioHealth, a measure that is more focussed towards the competitive advantages of Luxembourg's industrial base than on its particular benefit for the health system.[156] Admittedly, biohealth represents an emerging technology in health sciences, penetrating into new areas like biobanking, bioinformatics, nanatechnology or digital simulation based on large sets of anatomical, physiological or phatological data. Apart from some US research institutes, it is predominantly Luxembourg partners such as the Integrated Biobank of Luxembourg, the Public Research Centers (CRP) Santé, Henri Tudor and Gabriel Littmann, and the University of Luxembourg which gain from the funding.[157] However, assuming the success of such investments, who if not the Luxembourg health insurance system and those in the Greater Region will become the major clients or at least purchasers of the services offered by the so-called "partnership for personalised medicine"[158]? It could have been beneficial to demonstrate how the Luxembourg population via its public health care system can equally gain in the end from the huge Luxembourg public investment in this new health technology.

2.2.4 Critical assessment of reforms, discussions and research carried out

In previous years, health spending has increased by an average of 6% per year and even passed the rate of GDP growth.[159] It was partly caused by an increase in the number of benefits, a shift to more specialised and expensive care, but also by a significant extension of health services and a substantial increase of the level of income earned by providers. Cost control in health care spending is considered relatively weak by international comparison; the flow and quality on health information could be improved and the role of hospital managers with regard to control of the physicians' performance could be strengthened.[160]

In 2009, the financial situation of the health insurance could no longer be kept in balance. The challenges of the financial crisis and the inexorable ageing of the population pay tribute to the health financing situation of the health and insurance system. Both need to be strengthened to deal with these structural risks of the health system more effectively.[161] The "stability pact" as negotiated by the quadripartite partners in autumn 2009 demonstrated the shared awareness of the financial challenges and the urgent requirement to adequately adjust the current system. Since then, health system professionals have experienced heavy labour-intensive months. Given the small size of the country it is few surprising that many government, provider and social partner representatives were involved in preparing and reconciling the quite large number of specific reform proposals.

[155] MS/MSS, 1/2010, 6-9, MS/MSS, 3/2009, 14-15.
[156] Government of the Grand-Duchy of Luxembourg, October 2009, p. 27, PwC 2010, 44-45.
[157] Stoldt, Jürgen, 2009, p. 15-16.
[158] Ibid.
[159] OECD 2008,98.
[160] OECD 2010, 10.
[161] CES 2009, 64.

The final decision on which of these proposals to concentrate on within the entire ambitious reform will remain a major challenge. It falls in a time in which all economic sectors and private households are confronted with austerity measures to bring the public budget back into balance. Thus the minister for health and social security will have a tough job to find public backing for any further cuts concerning the volume and financial coverage of health service benefits. In particular, providers will have little problem in aligning public opinion with any argument that the reform measures taken might substantially threaten the quality of the health care service.

Another major drawback concerns the poor quality of medical data. Instead of applying the ICD-10 code in its full shape, Luxembourg makes only use of three digits, does not connect the information of the discharge diagnosis to the payment of doctors and hospitals, and in its national nomenclature of medical procedures, uses a code of considerably low granularity by international standards. In consequence, the low quality of data jeopardises the systems' statistical analysis. The non-transparency also negatively affects solid health planning, the negotiation of fair tariffs and any combat of fraud and abuse. This puts Luxembourg at risk of becoming internationally isolated. The available data do not meet the standards required for health performance and outcome measures and comparisons.[162]

Despite a veritable governmental effort in health prevention, it is not only the CES who criticises the lack of a comprehensive view of all the many efforts undertaken by different Ministries, organisations and counselling centres.[163] Preventive health care seems neither centrally coordinated nor reported or budgeted in a concise manner. Apart from the presentation of the major programmes (www.sante.lu), little is known about the policy cycle for preventive health measures, the programmes' preparation and budgeting, or the (cross-) responsibilities of various actors for implementation, impact and cost-benefit analyses.

The new hospital plan of 13 March 2009, despite the recognition of an emerging trend toward ambulatory surgery and day care (Art. 18), largely perpetuates the status quo with a slight increase in the number of beds for some specialised centres of competence for cardiology and geriatrics. The plan neither prepares for a major reorganisation of the sector with respect to ambulatory surgery or integrated care services, nor contains provisions for mandatory cooperation in certain areas, such as information technology, purchase and logistics, nor makes doctors or hospitals accountable for a prudent use of public resources.[164] However, one new chapter takes into consideration new measures of enhanced quality management and patient safety.[165]

Furthermore, the health care services in Luxembourg seem inappropriately prepared to meet the challenge of globalisation of health care and greater mobility of patients. Due to its opacity in terms of supply and quality of care, caused by a low level of medical documentation standards, detailed and expressive information is difficult to obtain from outside the country. High labour costs further challenge the system's attractiveness for foreigners.

With regard to an increased influx of foreign doctors, the ideas of potential limitation of the number of doctors or abandoning the mandatory convention for doctors has appeared on the political agenda.[166] The latter would on the one hand risk introducing a two-tier medical sector and eroding the fundamental element of solidarity to the detriment of the poorer layers of the population, while on the other hand, stronger competition among providers for the

[162] Marx, 5.3.09.
[163] CES 2009, 56.
[164] Feist, 16.01.09, Plan hospitalier national. Memorial A-54 of 23 March 2009.
[165] MS/MSS 3/2008, 10-11.
[166] Feist, 26.03.09.

better-off and profitable and high-tech services could weaken the system's balance in term of geography and fields of medical specialisation.[167] However, in its ruling on Hartlauer (C169/07), the European Court of Justice has made its position on limiting the right of establishment very clear.[168]

Despite its exclusive position, the purchasing power of the public health insurance fund institution seems unexpectedly low. As a public body responsible for orchestrating health care consumption to maximise value for its members and society, much stronger requirements for medical justification of charged services and stricter control of providers to operate economically should be expected. Here, specialised and internationally connected institutes for health economics and evidence-based medicine, which prospectively gain financial support by EU as stipulated by the Directive 2008/142 EC in preparation[169], would be of major help.

The guaranteed universal access to a very large benefit package, in particular, has turned the health and nursing care industry into a prosperous and labour-intensive economic sector and thus contributes by and large to three of the four priority areas of the Lisbon Strategy. The number of health professionals has increased over the last decade, on average, by 6.5% per year.[170] Employment in nursing homes and the home care sector rose between 1999 and 2006 by as much as 10% on average.[171] Despite its acknowledgement of the promotion of increasing research and investments in new biohealth industries, the Government seems not to be aware of the important contribution of the social security sector to national employment and economic growth.[172] However, in the medium term, increasing demand for more developed and hence more costly health care services will also bring the system under financial pressure. The CES is of the opinion that the state and health sector players must meet the balanced budget of health insurance, while maintaining a functioning health system.[173]

The overall steering of health insurance involving all stakeholders – government, social partners, National Health Fund, doctors, hospitals and other providers – is insufficient to meet the needs of change, especially against a backdrop of economic and financial constraints. The past has shown that it is almost impossible to gain hospitals' and clinicians' agreement for either a common conceptual orientation or an integrated organisational functioning. Therefore, it is imperative to optimise the management and coordination of the health system and to identify inherent efficiency gains and saving potentials.

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167 CES 2009, 59.

168 ECJ C 169/07 Hartlauer Handelsgesellschaft vs. Wiener Landesregierung [10 March 2009]. On March 10, 2009, ECJ ruled with regard to the freedom of establishment and services (Art. 43 and 48 EC) in health care that Articles 43 EC and 48 EC preclude national legislation under which authorization is necessary for the setting up of a private health institution, and preclude refusal of such authorization with a reason that there is no need for such that institution, if group practices in this system are not bound to the same conditions.

169 Proposal of a Directive on the application of patients' rights in cross-border health care (COM 2008/414), Art. 15).

170 www.statsecu.etat.lu, Professions de santé à partir de 1995 [RG/AM/IGSS, 2008].

171 www.statsecu.etat.lu, Le personnel des établissements d'aides et de soins à partir de 1999, Evolution du personnel des réseaux d'aides et de soins de 1999 à 2007 [RG/A_D/IGSS, 2008], own calculations.

172 Government of the Grand-Duchy of Luxembourg, October 2009, 27.

173 CES 2009, 6.

2.3 Long-Term Care

2.3.1 Overview of the system's characteristics and reforms, debates, political discourse and scientific assessment

Ten years after the implementation of long-term care insurance, this youngest pillar of the Luxembourg social security system still enjoys a high degree of acceptance among the population. In particular, its generous benefit package not only allows many people in need of assistance with their personal care to remain in their home environment, but equally puts the care of elderly on a secure footing and has created a prosperous economic sector and labour market for home and inpatient care. These strengths also have their costs, and after an affluent beginning the current account balance went into deficits from 2004.[174] A substantial increase of 40% in the individual contribution rate (from 1 to 1.4% of gross salary) as from 2007 has remedied the risk and brought about an annual reserve of 8-11% of total revenues. Based on a preliminary financial evaluation, the law of 18 December 2009 on the public budget 2010 stipulates, in Art. 54, that both, the 2009 state budget participation of EUR 140 million and the contribution rate at 1.4% will equally be applicable for the year 2010. However, expected demographic changes and the consequences of the current crisis require a more thorough re-evaluation of the whole setting. Currently, IGSS undertakes the actuarial analysis of the long-term care insurance scheme, originally planned for 2009. Results are now expected by mid-2010.

On 16 March 2009, the Grand-Duke finally signed the controversial bill on palliative medicine and euthanasia. The law entered into force by 1 July 2009 and quickly became famous, but less for its content and the fact that Luxembourg is the third European country after Belgium and the Netherlands where euthanasia is no longer a punishable offence nor for the entitlements of certain rights to palliative care, and more for the fact that the initial Grand Duke's veto in 2008 caused an amendment of the constitution to restrict his rights to just the signature of bills. [175] The palliative services are financed by the long-term care insurance. Before, the long-term care insurance already paid these services in a comparable way based on an internal procedure, which ceased at the moment the new law became effective. Special administrative procedures are now in place, which allow the physician in charge to lodge the request for palliative services on behalf of the patient. In spring 2010, special tariffs for palliative services were determined.[176]

Long-Term Care Insurance

As for health insurance, public long-term care insurance guarantees equal access to the whole working population including cross-border workers, irrespective of age and health status. The insurance is organised as a social insurance system which is mandatory for all persons insured under Luxembourg's health insurance scheme. It offers access to continuous insurance benefits from the first day of membership.[177]

The so-called "Cellule d'évaluation et d'orientation (CEO)" is the competent organisation for the assessment of dependency status and evaluation of long-term care needs under the responsibility of the Ministry of Social Security. In 2009, the organisation received 5,347 admissible requests for classifying or reclassifying the individual need for nursing care services, of which two-thirds were new, i.e. lodged for the first time. About 20% were refused

[174] IGSS November 2009, 187.

[175] Etienne, 9.3.2009.

[176] MSS 2010, 44.

[177] Only people covered for long-term benefits by international organisations are excluded, and voluntary health insurance members are restricted for benefit entitlements to a one-year qualifying period.

by the CEO. Another 6,625 applications concerned (minor) technical aids and housing adaptations.[178] Caused by previous criticism of the long processing delays, in 2009 both the handling procedures and the evaluation instrument became subject to reforms. Now, individual records are under the responsibility of one employee in charge from the initial application to the final placement in a care service, making use of specialists' opinions whenever required. The evaluation instrument was simplified and made more transparent. All applications are handled within four months.[179]

The crucial criterion to become entitled to the benefits is proven dependency on assistance from a third person for the activities of daily living (ADL) for a minimum of 3.5 hours per week. Even below this threshold there is still a possibility of receiving means-tested financial assistance from the National Solidarity Fund to pay for the services.

Currently the nursing-care insurance scheme accounts for more than 10,000 beneficiaries receiving benefits in kind or cash benefits on a regular basis.[180] Benefits are usually offered in kind and carried out either by accredited nursing homes or ambulatory home care providers. It is also possible to receive only cash benefits or a combination of cash benefits and benefits in kind instead. However, the cash benefit part is always limited to 10.5 hours per week and requires that an informal caregiver is able to provide care instead of the professional organisation. The long-term care insurance scheme takes over the costs for counselling of the informal caregiver and also pays his/her pension fund contribution.[181]

In inpatient nursing homes or homes for the elderly, the price for accommodation has to be paid by the resident himself. Despite the remuneration of all services related directly to care provision by either the health insurance or the long-term care insurance, the price of this accommodation is quite high. Unfortunately, there is no publicly available comparable information of the accommodation price per institution. In its latest practical guide for seniors, the Ministry of Family and Integration only publishes the monthly minimum rate for a bed in a double room of EUR 1,437.19 in 2008[182]. The lasted aggregated information dates back to 2005, when it varied between EUR 1,440 and EUR 2,896 per month for integrated centres for the elderly and between EUR 1,335 and EUR 3,120 for nursing homes.[183] For comparison, in 2003, 75% of the households of people over the age of 60 had at their disposal an amount equal to or less than EUR 2,500 per month, and 30.4% had less than EUR 1,250.[184] The National Solidarity Fund provides mean-tested support of these costs (*accueil gérontologique*). In 2008, 678 people received on average EUR 824 per month.[185] The fact that these prices are not available in a comparable and transparent manner is inexcusable. It was in this light that the necessity for the study on care analysis and analytical accounting was born (see section on 'Impact assessment' below).

178 MSS 2010, 37-39.
179 MS/MSS 1/2009, 3-4.
180 IGSS November 2009, 150.
181 Kerschen 2009, 149 – 151.
182 MiFa, 2008, 76
183 Kerger 2008, 162.
184 Ibid.
185 IGSS November 2009, 239-242.

Financing

The latest available Figures on public and private long-term care expenditure [186] date back to 2005, where it amounted to EUR 414 million and equalled 1.52% of GDP.[187] More recent information at national level only refers to public expenditure,[188] which amounted to EUR 402 and 431 million in 2006 and 2007 respectively.[189]

In order to ensure the financial viability of the long-term care insurance scheme and limit the burden of public expenditure, the law of 23 December 2005, of which several parameters were amended in 2007, addresses several features in order to ensure the financial equilibrium of the system. The most relevant are:

- The contribution rate for individuals has been raised to 1.4%, payable without any upper limit on all earnings, including fringe benefits and capital.
- The substantial state contribution, previously 45% of total expenditure, was frozen at a nominal amount of EUR 140 million (the level of 2006 spending)
- The upper financial reserve limit of 20% of total expenditure was set aside.

Long-Term Care Services

Market entry to the care-giving sector is restricted to organisations which are approved by the Ministry of Family Affairs based on the fulfilment of certain quality standards and after adhesion to a framework contract with the long-term insurance organisation, determining the rights and obligations for executing the nursing care services.

The sector knows four types of service: in 2008, there were

- 14 ambulatory networks for home care with two dominating institutions (Stëftung Hëllef Doheem, Help),
- 45 day care institutions
- 35 intermittent care centres (for alternating short-term stays according to the actual level of dependence)
- 51 nursing homes and integrated homes for the elderly with a capacity of 4,805 beds in 2005.[190]

In 2007, this last area employs roughly 61% of the sector's workforce. The providers are remunerated by the long-term care insurance scheme according to a sector-specific fee per hour (valeur monétaire).[191] For 2008 and 2009, the long-term care insurance and COPAS, the representative association for nursing homes and integrated homes for the elderly, could not agree on the hourly fee. Similar fees for both types of institutions were no longer seen as appropriate. In 2008, the arbitrator proposed a value of EUR 42.52 and strongly

[186] According to the joint questionnaire of Social Health Accounts (OECD – Eurostat - WHO HQ) as used in indicator HC-P13 (Total spending on long-term care as a percentage of GDP).

[187] Source: HC-P13, update July 2008.

[188] Public expenditure on long-term care includes: 1. Current expenditure of the long-term care insurance system and those costs for accommodation in nursing homes that are borne by the National Solidarity Fund (accueil gérontologique).

[189] IGSS November 2009, 187, 239 and 242. , www.statsecu.etat.lu ,Etat détaillé des dépenses [RG/PM/IGSS, 2008], Fonds National de Solidarité, Comptes financiers Etat détaillé des dépenses, (en EUR). See also: Statec, January 2010, 293 These figures are still preliminary, as due to often considerable delays in the settlement of accounts with the insurance fund, the final expenditure for Luxembourg is likely to increase substantially even two years after the reporting period.

[190] IGSS November 2009, 143-144 and Kerger 2008, 151.

[191] IGSS November 2009, 190.

recommended to the committees for quality in long-term care and for standardisation to progress in the development of results in order to facilitate future negotiation. As one recurring conflict he mentioned the parallel application of two different sector-specific collective contracts for hospital and nursing home staff and suggested to orientate only toward the latter.[192] In 2010, the framework contract between providers and long-term care insurance took up these suggestions and incites providers to leave the collective contract for hospitals.[193] For 2009, the arbitrators' proposal, which fully followed the providers' position, was rejected by the long-term care insurance fund and subsequently led to a procedure before the high council of social security.[194]

Integrating Out- and Inpatient Care services

The biggest network of home care services, "Hëllef Doheem", has developed and is implementing a number of innovative approaches in order to better link acute and long-term care periods:

- As an ambulatory care provider, it also runs offices in hospitals to improve the coordination between in- and outpatient caregiving ("infirmier de liaison"). The services are usually paid for by additional resources, such as donations. Apart from the quality objectives, the concept further gains competitive advantages in acquiring the hospital's patients as new long-term care clients. Therefore it is little surprise that the competitors have followed this example.
- A second pilot application concerns the so-called "reference nurse", a concept of care coordination and management by a specific care-giver. The reference nurse supervises the care plan for a number of familiar patients and coordinates with the individual health and care networks of this person (doctors, social assistants, relatives). The concept is reported to be quite successful.[195]
- The third project, "Night watch", started in March 2009 and aims at developing and scientifically evaluating the concept, demand and costs of professional night watch services, for which demand in 2007 was initially estimated at 350 persons. The CRP-Santé is providing scientific backup to the project.[196]

2.3.2 Impact assessment

Quality

Luxembourg has taken action to improve the quality and transparency of long-term care. A quality committee for long-term care was established in 2007, composed of government delegates, representatives of the providers and the Luxembourg patient organisation "Patiente Vertriedung asbl". Since then it has contributed to the improvement of documentation of care-dependant residents and hygiene standards.[197] The CEO, equally responsible for assessing the dependent status of a person, monitors the standards set and measures misbalances between the care provided and the needs of the dependent person.

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192 MSS 2009, 39. This proposal has been taken up by the latest modifications of the framework contract between providers and long-term-care insurance.
193 MSS 2010, 45.
194 MSS 2010, 44.
195 MS/MSS 1/2009, 6.
196 MSS 2009, 45.
197 MS/MSS, 4/2009, 5-6.

In 2006, patients' satisfaction in the area of home care was measured for the first time through a survey conducted by the institute CEPS/INSTEAD.[198] Its results gave grounds for some new reform measures to be implemented from 2008, such as accelerated administrative procedures, minimum requirements for keeping patient records, as well as ensuring that information on how an application has to be completed will now be provided in 4 languages (Luxembourgish, French, German and Portuguese). In 2009, an evaluation survey was started on the satisfaction of dependent people living in health care and long-stay institutions. Results are expected for mid-2010.[199]

Analytical Accounting

In 2007, a controversial debate between providers and third-party payers about the source of financing for domestic services in nursing homes led to a pilot study on how to best bring more transparency to the pricing and planning of nursing care services. In 2009, after successful completion of the pilot, the Ministries of Social Security and Family Affairs commissioned the sector-wide implementation of an analytical accounting system, to be jointly developed by government, long-term care and provider representatives, and to become binding for all 51 nursing homes. From May 2010 onwards, an exhaustive self-recording of all services rendered by all nursing-home employees will take place on eight days a year (2 days per quarter). An exhaustive conciliation process on specific allocation keys for various cost centres will now enable data on the nursing-homes' expenditures and revenues to be assigned to the paying authorities and individuals. The implementation process is technically prepared and moderated by PriceWaterhouseCoopers with scientific support from the University of Applied Sciences of Jena. The unified analytical accounting system (*Kostenträgerrechnung*) in preparation is expected to represent the right instrument for greater transparency and better national and in-house planning of long-term care services.[200]

In December 2009, the project achieved an important interim result, namely the solution of the above-mentioned decisive conflict on the remuneration of domestic services. It confirmed the existence of a specific workload of these services for care-dependent residents, which outnumbers the workload for non-dependent residents. To annually determine these specific charges, up-to-date data are expected to be collected in the frame of the periodically self-survey described above and conducted by each institution as from 2011. Therefore, as an intermediate measure, two flat-rates have been established by Art. 55 of the law of 18 December 2009 on the public budget 2010 for a period of two years, distinguishing services that are directly assignable to one resident from those that are only indirectly linked to an individual.[201]

Cost-Analyses

The law of 23 December 2005 also stipulated the execution of an in-depth projection of the financial situation of long-term insurance, which IGSS is about to undertake. Due to the government priorities to reform the health insurance system first, this study originally announced for 2009 was postponed. Results are now expected in summer 2010. The current favourable demographic situation, as described under the section on health care, equally applies to long-term care. However, the same holds true for the inevitable sharp rise in older people in the long run.

[198] Kerger 2008, 203-230.
[199] MSS 2010, 40.
[200] MS/MSS, 4/2009, 8-11.
[201] Ibid.

2.3.3 Critical assessment of reforms, discussion and research carried out

Since its implementation in 1999, long-term care insurance has led to a substantial change of the market for long-term care provision. Expenditure by the long-term care insurance system is rising primarily because of the growing number of beneficiaries and the constantly expanding range of care and services. The capacity of specialised nursing care homes has admittedly improved access to the system, but on the other hand, has also weakened the originally good financial situation of the long-term care insurance scheme.

Therefore, the government's impetus to foster quality improvements, enhance standardisation, strengthen technical progress and master system inefficiencies can only be acknowledged. Especially those projects which aim at bringing transparency and performance standards to the system seem to appropriately serve the political requirements for better steering of the sector. The implementation of more effective and transparent procedures to assess the dependency status and evaluate the volume and specificity of the support needed equally help to increase the people's faith in the administrative system. However, there is still room to improve information on the quality and the relevant prices for long-term care sercives and nursing home accommodation.

The system-wide unified analytical accounting system, which was developed over the last three years, is now in its inception phase and will have to demonstrate to live up to expectations. For the hospital sector, it already serves as an example to achieve greater transparency in pricing and planning. The actuarial study by IGSS will further shed light on how much pressure, caused by the ageing of society coupled with the consequences of the financial and economic crisis, the system will be able to withstand and for how long.

As the long-term care insurance system is a true blessing for elderly and dependent people as well as for a large number of caregivers, it can only be hoped that it can keep up its momentum, increase the service quality and stabilise its financial basis. Even though the nursing care services are quite domestically orientated, any research and actions taken that bring and keep Luxembourg's nursing care services at a top level of quality and cost-efficiency by international standards should be welcomed.

3 Impact of the Financial and Economic Crisis on Social Protection

The international financial and economic crisis has heavily affected Luxembourg's economy with substantial adverse effects on the national labour market and the fiscal sustainability. The long-lasting period of considerable economic expansion has come to an end.

At the onset of the crisis, Luxembourg participated in the rescue of two cross-border banks with substantial market share in the national economy, namely Fortis and Dexia groups. Furthermore, three Luxembourg subsidiaries of Icelandic banks (Glitnir, Kaupthing and Landsbanki), where the Icelandic government ran out of resources to support these subsidiaries, were wound up by a special bank resolution process established in Luxembourg, through which a bank in trouble can be stripped of its management power by the supervisory body, for a cost of EUR 300 million, which was covered by the existing deposit insurance scheme.

Thanks to the largely foreign ownership of the numerous resident financial institutions, Luxembourg could withstand the crisis without extensive financial damages. 95% of the banks' assets are hold by foreign financial institutions. As a consequence the rescue of the losses of bank subsidiaries established in Luxembourg had to be borne by other countries.

However, the example of Icelandic banks exemplifies the remaining risk for the host country, if a foreign government runs short in resources. To sum up, Dexia and the Icelandic banks did not require much government support. However, the rescue for Fortis alone obliged the Government to release a loan of EUR 2.5 billion (6.4% GDP), which was later converted into equity. Now Luxembourg holds one-third of the capital of the renamed bank BGL BNP Paribas, which the government intends to divest in the near future.[202]

The real challenge of the financial crisis lies in the large negative impact on government revenues. Taxes paid by banks fell by two-thirds in 2008 to a yield of less than 1% of GDP. Equally, the tax on investment fund subscriptions (on the value of assets under subscription), fell by one-fifth in 2008. Both effects are expected to continue and the total loss of tax revenue can only be determined after a number of years that it will take to reveal corporation profits and the subsequence corporation taxes to be paid.[203]

The Government further reacted with the quick release of a very large economic stimulus package of 3% of GDP in 2009 and further additional measures for 2010, consisting of additional public investment, increases in income tax thresholds and the establishment of a short-hour working scheme, as described below.[204] However, due to the openness of the economy, the impact on national demand was only modest, which is inherent to a small regional and open economy like Luxembourg.[205] Further to these stimulus measures, the public budget was challenged by large drops in fiscal revenues and automatic stabilisers, which turned a previous surplus of 3% in 2007 into a considerable deficit of around 4% of GDP in 2009. The governmental consolidation plan envisages to re-establish a small surplus within five years by setting an annual consolidation target of around 1% of GDP.[206]

One part of the deficits are planned to be covered by raising existing taxes (such as the maximum marginal tax rate), limiting tax reductions (for bonus payments) or implementing additional taxes (i.e. for financial transactions). Furthermore, wage indexation might become subject to an adjusted basket of goods (excluding the prices of fuel and some other excise products). Savings on expenditure, in particular for social transfers to households, are intended to make up the rest of the consolidation plan. The following social benefits are under scrutiny: annual school year allocation, child benefits above the age of 21, reduction of parental leave from 6 to 4 months, and the interest subsidy for property ownership. With regard to pensions, the bi-annual wage adjustment is proposed to be reduced, and/or distributed to two years (2011 and 2012).[207]

However, the large future pension liabilities, which due to the change of demographic patterns and the current generous pension benefits are expected to increase from 8.7% of GDP in 2007 to 24% in 2060[208] will require immediate reforms. Otherwise, the scenarios to keep the current system in balance will require constantly higher contribution rates up to an unrealistic level of 40% of gross income by 2040[209]. Today's beneficial high percentage of relatively young workers will logically lead to a growing number of pensioners in the future. Thus, the redistribution principle of the system requires continuous and sustainable economic and employment growth in order to ensure its long-term viability. Current 40-year forecasts,

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202 OECD 2010, 102-112.
203 OECD 2010, 106.
204 OECD, 2010, 28.
205 OECD 2010, 25. In contrast, Luxembourg also gains for the stimulus packages in neighboring countries.
206 MF 2010, 16.
207 Prime Minister's State of Union speech on 5 May, 2010 (www.wort.lu) accessed on 5 May 2010. see also: http://www.mf.public.lu/actualites/2010/04/frieden_tripartite_130410/index.html (accessed on 20 April 2010).
208 European Commission 2009.
209 UEL 2009.

still based on assumptions of stable 2% growth in both productivity and inflow of labour, already predict a gradual deterioration in financial stability from 2020 onwards.[210] Logically, the structural slowdown in employment growth caused by the crisis will result in an additional shortage of financial resources. This new burden for the pension system will also affect the financing of health and nursing care, which will additionally enlarge age-related spending and, in the current system, will equally depend on additional public co-funding.

Several institutions downsized their forecasts for Luxembourg's annual real GDP growth: the OECD from 3.5 to 2.5%, STATEC also by 1% to below 3.5% and the Central Bank to below 4%. [211]

Despite the introduction of a large-scale short-time working scheme, which compensates employers for the wages paid to their employees for pre-defined non-performing working-hours of their contractual working time, the job market has been hit hard by the financial crisis. Unemployment has risen to a rate of above 6% of the resident labour force. In February 2010, the *Comité de Conjoncture* analysed the new labour market statistics, which show that in January 2010 the unemployment rate established an historical high of 6.4% (January 2009)[212].

In 2008 and 2009, the industrial sector was affected worst. However, here the subsidies for short-time working hours have maintained the number of workers relatively stable, whereas temporary work decreased by 50%. Almost 4% of the labour force benefited from the short-time working measure at the peak of the crisis and early 2010 around 3% still do.[213] The *Comité de Conjoncture* is in charge of scrutinising whether the applying firms (still) fulfil the criteria for being supported (substantial drop in orders).

In the beginning, other sectors, such as crafts, retail and non-financial services, withstood the crisis and show only limited contraction of around 3% in 2009.[214] Thus, the sharp decline in the balance sheets of the banks has only shown limited negative effects in the national economy. For the latter, the special commission of the Chamber of Deputies expects trend reversals in the near future in the light of an upcoming restructuring of the financial market.[215] Generous social benefits with high replacement rates, a lack of any incentives to find a new job and so on, inhibit the unemployed from actively searching for a new job opportunity. [216] In addition, the country's competitiveness is largely challenged by very high unit labour costs, which result among other things from the automatic wage indexation to inflation (based on headline prices, which include highly volatile prices for food and energy).

The statistics must be read carefully with respect to cross-border workers. Those who lost their job in Luxembourg will not show up in Luxembourg's unemployment statistics, but instead receive unemployment benefits in their country of residence based on the Directives 1408/71 EEC and 883/2004 EC which replaced the former from 1 May 2010. Thus, due to the state of Luxembourg's economy, the rising unemployment mentioned above is likely to be much higher.

The financial model of the public pensions system, organised as a pay-as-you-go system (PAYG) paid from current contributions with general financial participation from the government of one-third of the individual pension contribution, has built a very solid financial

[210] IGSS 2005.
[211] OECD 2010, 26.
[212] http://www.mte.public.lu/actualites/communiques/2010/02/20100225_ccj/index.html.
[213] MF 2010, 7. see also: OECD 2010, 27.
[214] OECD 2010, 102.
[215] Chambre des Députés 2009, 38.
[216] OECD 2010, 12.

basis. Thanks to the continuous economic growth over years combined with the influx of cross-border workers in recent decades, the pension system has been able to accumulate a large reserve of 3.5 times yearly expenditure, which currently equals 28% of GDP, which represents an extremely large share of government assets.[217] Furthermore, cautious investment rules only permit less than 2% of investments in shares.[218] This favourable overall situation makes the system likely to withstand the economic crisis for at least another 1.5 decades and thus no short term measures are required.

Some of the supplementary and private pension regimes, organised either as defined benefit (DB) or defined contribution schemes (DC), face significantly more difficulties due to the more liberal investment rules.[219] In fact, Article 6.1 of the law of 9 June 1999 on supplementary pension plans allows companies in case of general economic and financial crisis to adjust or repeal the scheme, even to the detriment of the beneficiaries.[220] Although a number of companies operating such a plan were seriously considering this option at the onset of the crisis, so far, no one has made use of it. In contrast, the number of companies which have established one or more pension plans even rose in 2009 by roughly 10% to 1,825.[221] Equally, the Supervisory Authority of Insurance Institutions reports for 2009 an increase of 18.52% of annual contributions to individual private pension plans.[222]

Irrespective of the financial crisis, the public pension system will be challenged anyway in the course of the next decade, due to the change of demographic patterns and its generous pension benefits. Today's beneficial high percentage of relatively young workers will logically lead to a growing number of pensioners in the future. Thus, the redistribution principle of the system requires continuous and sustainable economical and employment growth in order to ensure its long-term viability. Current 40-year forecasts, still based on assumptions of stable 2% growth in both productivity and inflow of labour, already predict a gradual deterioration in financial stability from 2020 onwards.[223] Logically, the structural slowdown in employment growth caused by the crisis will result in an additional shortage of financial resources. This new burden for the pension system will also affect the financing of health and nursing care, which all depend on additional public co-funding.

A first rough impact analysis of the economic and financial crisis on the various branches of social security currently guides the national debate on necessary austerity measures to keep the systems and the public budget in balance.[224] The health sector that enjoys an excellent reputation in the eyes of the public and among international experts for the outstanding quality of its services[225] is nonetheless challenged by the fact that the costs tend to get out of control. As a result of the financial crisis, if not before, it has become irrevocably clear that partial corrections of the structure of the existing system are absolutely vital. The enormous endeavours undertaken since fall 2009 by the decision-makers demonstrate that they have not only realised this necessity, but are also trying to jointly identify tailor-made strategies to the country-specific problems. There is little or no sign of simplistic copies of foreign health system components among the various proposals.[226]

[217] MF 2010, 22.
[218] MS/MSS 3/2008, 8-9.
[219] OECD 2009 (2), 74.
[220] Law of June 8, 1999 on supplementary pension plans (Social Security Law).
[221] Information by IGSS.
[222] Commissariat aux Aussurances, 2010.
[223] IGSS 2005.
[224] MF 2010.
[225] OECD 2008, Health Consumer Powerhouse 2009, TNS-Ilres 2009.
[226] Corps Médical 2010.

Unfortunately, whichever of the interesting reform proposals for the health system the government decides to prioritise, they will be assessed against the background of all the other austerity measures that will affect businesses, the labour market, the public and individuals' households. Opponents of structural reforms in health will therefore be given ample room for provocative arguments to align public opinion with the view that reform will only sacrifice the quality of health care.

References

ADEM (ADMINISTRATION DE L'EMPLOI) (March 2010). Bulletin Luxembourgeois de l'emploi, Luxembourg

AMMD (ASSOCIATION DES MÉDECINS ET MÉDECINS DENTISTES) (2010). Le Corps Médical, Bulletin spécial, Luxembourg

AMMD (ASSOCIATION DES MÉDECINS ET MÉDECINS DENTISTES) (2010). Le Corps Médical, 48th year, No. 3/2010

AMMD ASSOCIATION DES MÉDECINS ET MÉDECINS DENTISTES) (2010). Le Corps Médical, 48th year, No. 4/2010

AXA (April 2008). Baromètre AXA de retraite : Résultats Luxembourg 2007-2008, http://www.retirementscope.axa.com/lib/rs/uploads2/europe/luxembourg/AXA_report_luxembourg_2008.pdf

AXA (November 2009). Baromètre AXA de la retraite : Etude sur le comportement des résidents luxembourgeois face à l'épargne de la retraite, http://www.axa.lu/pdf/presse/Barometre_AXA_2009_-_comportement_face_a_l_epargne_-_06-11-09_VF_web.pdf

BANQUE CENTRALE DE LUXEMBOURG (BCL) (November 2009). Avis de la Banque centrale du Luxembourg (BGL) sur le Projet de Loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercise 2010, Luxembourg, p. 35-38

BECKER, Amélie (2009). De l'Assurance-Maladie à l'Assurance-Santé au Grand-Duché de Luxembourg : Pourquoi la création d'une Caisse Nationale de Santé ?, in : Bulletin luxembourgeois des questions sociales, Vol.26, 2009, pp. 31-79

BODSON, Lucile and SEGURA, Jordane (January 2010). Le divorce au Luxembourg en droit et en chiffres, CEPS/INSTEAD, Cahier no. 2010-1

CES (CONSEIL ÉCONOMIQUE ET SOCIAL) (April 2009). Evolution économique, sociale et financière du pays 2009, Annual assessment 2009, www.ces.public.lu/fr/avis/avis-annuels/2009-avis-annuel.pdf

CES (CONSEIL ÉCONOMIQUE ET SOCIALE) (September 2009). Les lignes directrices intégrées pour la croissance et l'emploi (2008-2010) regroupant les grandes orientation des politiques économiques (GOPE) et les lignes directrices pour l'emploi (LDE), avis, Luxembourg

CHAMBRE DES DÉPUTÉS (March 2009). Vers un nouveau modèle de croissance, Report of the special commission on "Economic and Financial Crisis", No. 5977

CHAMBRE DES SALARIÉS LUXEMBOURGEOIS (February 2010). Viabilité à long terme du système de pension – Eléments de reflexion, Luxembourg

CLÉMENT, Franz (March 2009). La "flexicurité" : définitions et applications au Luxembourg, CEPS/INSTEAD, Gouvernance & Emploi No. 7

C.N.E. (COMMISSION NATIONALE D'ÉTHIQUE) (2007). Les limites de l'accès aux soins de santé au Grand-Duché de Luxembourg, Avis 20

COMMISSARIAT AUX ASSURANCES (2010). Press release, http://www.commassu.lu/upload/files/193/COMMUNIQUE%202009_4.pdf

COUNCIL of the EUROPEAN UNION (March 2009). Council Opinion on the updated Stability Programme for Luxembourg, 7329/09, (http://ec.europa.eu/economy_finance/publications/publication_summary14429_en.htm)

COUNCIL OF THE EUROPEAN UNION (March 2009). Country-Specific Integrated Recommendations - Report from the Council to the European Council, Proposal for a COUNCIL RECOMMENDATION on the 2009 up-date of the broad guidelines for the economic policies of the Member States and the Community and on the implementation of Member States' employment policies, contribution of the Council (ECOFIN) (7444/09), http://register.consilium.europa.eu/pdf/en/09/st06/st06784-re02.en09.pdf

CONSBRUCK, Roger (2009). Panorama du système de santé luxembourgeois en 2009, Ministère de la Santé, Study Report, Luxembourg, http://www.sante.public.lu/publications/systeme-sante/politique-nationale-sante/panorama-systeme-sante-luxembourgeois-2009/panorama-systeme-sante-luxembourgeois-2009.pdf

EUROPEAN COMMISSION (2008), Introduction of uniform social security arrangements for all employees in Luxembourg, note 485/08

EUROPEAN COMMISSION (October 2009), Pension Schemes and Pension Projections in the EU-27 Member States – 2008-2060, Volume I, Occasional Papers No. 56, Brussels, http://ec.europa.eu/economy_finance/publications/publication16034_en.pdf

EUROPEAN COMMUNITIES (April 2009). 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060), Joint Report prepared by the European Commission (DG ECFIN) and the Economic Policy Committee (AWG), http://ec.europa.eu/economy_finance/publications/publication14992_en.pdf

ETIENNE, Henri (9.3.2009). Es besteht noch viel Klärungsbedarf, Tageblatt

FEIST, Peter (16.01.2009). Schau'n wir mal, d'Land

FEIST, Peter (06.03.2009). Die Labor-Blase, d'Land

FEIST, Peter (20.03.2009). Die unendliche Geschichte, d'Land

FEIST, Peter (19 February 2010). Gegenrede, d'Land

FEIST, Peter (19 March 2010). Mikadospiel, d'Land

FEIST, Peter (02 April 2010). "Ich stehe auf keiner anderen Seite", d'Land

GENEVOIS, Anne-Sophie et al. (2005). La problématique du maintien en activité des travailleurs âgés : Bilan et perspectives, Cahier PSELL n°149, CEPS/INSTEAD, http://www.ceps.lu/pdf/3/art1084.pdf

GENEVOIS, Anne-Sophie (September 2009). Zoom sur les retraités au Grand-Duché, CEPS/INSTEAD, No. 60

http://www.statistiques.public.lu/fr/publications/thematiques/VieSociale/Vivre_au_Luxembourg/2009/60_2009/60_2009.pdf

GOVERNMENT OF THE GRAND-DUCHY OF LUXEMBOURG (September 2008) National Strategy Report on Social Protection and Social Inclusion (NSR), Luxembourg

GOVERNMENT OF THE GRAND-DUCHY OF LUXEMBOURG (July 2009). Governmental Programme 2009-2014, Luxembourg,

http://www.gouvernement.lu/gouvernement/programme-2009/programme-2009/programme-gouvernemental-2009.pdf

GOVERNMENT OF THE GRAND-DUCHY OF Luxembourg (October 2009). Plan national pour l'innovation et le plein emploi - Programme national de réforme du Grand-Duché de Luxembourg dans le cadre de la stratégie de Lisbonne, Luxembourg

GUIGOU, Jean-Daniel, LOVAT, Bruno and SCHILTZ, Jang (February 2010). Les retraites au Luxembourg: modélisation et évaluation d'un système diversifié avec répartition et capitalisation, Luxembourg

HEALTH CONSUMER POWERHOUSE (2009). Euro Health Consumer Index 2009, Brussels

HOHMANN, Jürgen (2009). Stakeholder involvement in the OMC, Country report Luxembourg, http://www.stakeholders-socialinclusion.eu/site/en/outputs/cr-lu

IGSS (INSPECTION GÉNÉRALE DE LA SÉCURITÉ SOCIALE) (2005). Bilan technique de la période de couverture 1999-2005, Luxembourg

IGSS (INSPECTION GÉNÉRALE DE LA SÉCURITÉ SOCIALE) (March 2008). Bilan sur la législation concernant l'incapacité de travail et la réinsertion professionnelle, Luxembourg

IGSS (INSPECTION GÉNÉRALE DE LA SÉCURITÉ SOCIALE) (2009). Rapport sur les mesures envisageables pour garantir la viabilité à long terme du système du pension, Luxembourg

IGSS (INSPECTION GÉNÉRALE DE LA SÉCURITÉ SOCIALE) (September 2009). Rapport sur la situation de l'assurance maladie-maternité, Luxembourg

IGSS (INSPECTION GÉNÉRALE DE LA SÉCURITÉ SOCIALE) (November 2009). Rapport général sur la sécurité sociale 2008, Luxembourg, www.statsecu.etat.lu

KERGER, Andrée (2008). Etude sur la satisfaction des bénéficiares de l'assurance dépendance, in: Bulletin luxembourgeois des questions sociales, 2008, Volume 24, 203-230

KERGER, Andrée and Wolf, Pascal (2008). Dépendance et gériatrie, in: Bulletin luxembourgeois des questions sociales, 2008, Volume 24, 132-169

KERSCHEN, Nicole (2009). La difficile reconnaissance de l'aidant dans l'assurance-dépendance luxembourgeoise. in: Bulletin luxembourgeois des questions sociales, Vol. 25, 2009, 145-172

KNEIP, Laurent (February 2008). L'avenir du système des retraites au Luxembourg, Master's Thesis at the Universities of Poznan and Freiburg

LEJEALLE, Blandine (February 2008). Évolution et place des femmes sur le marché du travail, Population & Emploi No. 30, CEPS/INSTEAD

MARX, Léon (03.03.2009). (Zu) teure Medizin, Tageblatt

MARX, Léon (05.03.2009). Noch sehr viel Nebel, Tageblatt

MARX, Léon (11.11.2009). Umstrittener Griff in die Reserven, Tageblatt

MF (MINISTÈRE DES FINANCES) (January 2010), 11th update of the Luxembourg Stability and Growth Programme, Luxembourg

MiFa (MINISTÈRE DE LA FAMILLE ET DE l'INTÉGRATION) (March 2008). Guide pratiques pour seniors, Luxembourg

MS (MINISTÈRE DE LA SANTÉ) (March 2009). Conférence nationale Santé – Vers un Plan national Santé, Luxembourg

MS/MSS (MINISTÈRE DE LA SANTÉ /MINISTÈRE DE LA SÉCURITÉ SOCIALE) (2008). InSight SantéSécu, Vol 1-3/2008

MS/MSS (MINISTÈRE DE LA SANTÉ/MINISTÈRE DE LA SÉCURITÉ SOCIALE) (2009). InSight SantéSécu, Vol 1-4/2009

MS/MSS (MINISTÈRE DE LA SANTÉ/MINISTÈRE DE LA SÉCURITÉ SOCIALE) (2010). InSight SantéSécu, Vol 1/2010

MSS (MINISTÈRE DE LA SÉCURITÉ SOCIALE) (January 2010). La Sécurité sociale – Code de la sécurité sociale – Loi et règlements, Luxembourg

MSS (MINISTÈRE DE LA SÉCURITÉ SOCIALE) (March 2010). Rapport d'activité 2009, Luxembourg

OECD (2008). Luxembourg, OECD Economic Surveys, Volume 2008/12, Paris

OECD (2009/1). Private Pension Outlook 2008, Paris

OECD (2009/2). The Financial Crisis – Reform and Exit Strategies, Paris

OECD (2009/3). Pensions at a Glance 2009 – Retirement Income Systems in OECD countries, Paris

OECD (2010). Economic Surveys Luxembourg 2010, OECD, Volume 5, 2010

PRICEWATERHOUSECOOPERS (PwC) (March 2010). HealthCast – The customisation of diagnosis, care and cure, Dallas, US

QUEISSER, M. and Whitehouse, E. (2006). Neutral or Fair ? Actuarial Concepts and Pension-System Design, OECD 2006, www.oecd.org/dataoecd/2/42/37811399.pdf

STATEC (2007). Labour force survey 2006, cahier économique – rapport travail et cohésion sociale, Luxembourg, Vol 106, 2007

STATEC (January 2010). 2009 Annuaire statistique du Luxembourg, Luxembourg

STOLDT, Jürgen (October 2009). Personalisierte Medizin: Hype oder Beginn einer neuen Ära?, in: No. 290, forum für Politik, Gesellschaft und Kultur, forum a.s.b.l. Luxemburg, pp. 15-16

THOMSON, FOUBISTER, MOSSIALOS (2009). Financing Health Systems in the European Union: Challenges and policy responses, WHO, European Observatory on Health Systems and Policies, Denmark

TNS-ILRES (February 2009). National Health Survey. Le Luxembourg dans le contexte international. Ministère de la Santé, Luxembourg http://www.sante.public.lu/publications/systeme-sante/politique-nationale-sante/national-health-survey-luxembourg-contexte-international/national-health-survey-luxembourg-contexte-international.pdf

UNION DES ENTREPRISES LUXEMBOURGEOIS (UEL) (July 2009). La réforme du régime général d'assurance pension – Position de l'UEL ; Luxembourg

WICTOR, Jean-Paul (2009). Commémoration du dixième anniversaire de la loi sur les régimes complémentaires de pension. In : Vol. 26, Bulletin luxembourgeois des questions sociales, Luxembourg, 2009, pp. 3-30

4 Abstracts of Relevant Publications on Social Protection

[R] Pensions

[R1] General trends: demographic and financial forecasts
[R2] General organisation: pillars, financing, calculation methods or pension formula
[R3] Retirement age: legal age, early retirement, etc.
[R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
[R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health

[H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
[H2] Public health policies, anti-addiction measures, prevention, etc.
[H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
[H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
[H6] Regulation of the pharmaceutical market
[H7] Handicap

[L] Long-term care

[R1] MF (MINISTÈRE DES FINANCES), « 11th update of the Luxembourg Stability and Growth Programme »,, January 2010

The annual update of the Luxembourg Stability and Growth Programme analyses the economic budget with regard to the quality and long-term sustainability of the public finances. Though examining the recent macroeconomic development, the government outlines its mid-term strategies in line with the budgetary decisions of the stability programme for the period 2009-2014.

[R1] OECD, « Economic Surveys: Luxembourg 2010 », Volume 2010/6, 2010

Based on a comprehensive external assessment of Luxembourg' economy at large, the OECD presents an extensive analysis, in this volume, focussing in particular on the impact of the financial crisis on fiscal sustainability, employment, Luxembourg's financial sector and living conditions. The pension system is examined under the chapter "Recovering from the crisis", which also covers fiscal policy. The report distinctively reminds on the challenge coming from high future pension costs due to ageing, generous benefits and the eligibility of increasing number of cross-border workers. It urges the swift initiation of pension reforms and proposes a variety of well-known measures, ranging from increasing the retirement age, reducing the replacement rate and abolishing the early retirement age. In this volume, health is only covered in negligible manner. One paragraph deals with cost control in health care, another with the restrictions of the number of pharmacies' concessions. Overall it is an outstanding international publication on Luxembourg.

[R1, R2] UNION DES ENTREPRISES LUXEMBOURGEOIS (UEL), « La réforme du régime général d'assurance pension – Position de l'UEL »; Luxembourg, July 2009 "Reform of the general pension fund system – Position of the UEL"

The preferred strategies of the Union of Luxembourg Enterprises (UEL) consist of reducing the replacement rate of pensions, extending the contributable period by postponing the retirement age, and financially incentivising the combination of a part-time pension with a reduced remunerated activity. The employers further propose to enlarge second and third tier pension plans, to reduce the contribution percentage and to abolish the indexation of pensions to wage development. However, they clearly

profess their commitment to a pension system based on solidarity and redistribution towards the poor.

[R1, R2] EUROPEAN COMMISSION, « Pension Schemes and Pension Projections in the EU-27 Member States – 2008-2060 », Occasional Papers No. 56, Brussels, October 2009

By reviewing the public pension schemes and the pension models used for the projections carried out for the next 50 years by the European Commission and the Economic Policy Committee of age-related expenditure included in the 2009 Ageing Report, the papers contributes in an excellent manner to the comparability of pension projections across Member States. The report presents a general overview of the pension systems in the EU, followed by pension expenditure projections. It encompasses public pension systems as well as privately managed pension plans. The overall structure is then repeated country by country, which help to understand the different forms of pension projections and to assess the respective results. As for all other countries, the Luxembourg chapter provides a well-written short overview of the pension system, which in its second part does not stint on projection details underpinning the challenges concerning long-term sustainability, Luxembourg is confronted with more of these than any other Member State.

[R1, R2, R3] CHAMBRE DES SALARIÉS LUXEMBOURGEOIS, « Viabilité à long terme du système de pension – Eléments de reflexion », Luxembourg, February 2010

"Long-term viability of the pension system – Elements of reflexion"

In its reflection report on the long-term viability of the pension system, the Chamber of Employees (CSL) opposes all proposals concerning the reduction of the replacement rate, the abolition of pension indexation or the early retirement measure as well as the change towards a more capitalised pension system. Instead, it sees room for increasing pension fund revenues by increasing the labour market participation of women and older workers, the abolition of the upper threshold of contributable income, levying income tax and introducing added value as a contributable base for employers. The report further summarises various recent national and international studies on the Luxembourg pension system.

[R2] WICTOR, Jean-Paul, « Commémoration du dixième anniversaire de la loi sur les régimes complémentaires de pension », in : Bulletin luxembourgeois de questions sociales, Vol. 26, Luxembourg, 2009, pp. 3-30

This article provides an interesting overview of the second tier pension system in Luxembourg from the preparation of the law of 18 June 1999 governing the complementary pension plans, through striking stages concerning their implementation and administrative control. It gives an insight into a sector which attracts relatively little attention in the literature. The descriptive review of the administrative measures to record and control complementary pension plans also makes it obvious that apart from the number of companies that have registered complementary pension plans in line with the legal requirements of the law, only little is known about the number of beneficiaries or the annual contributable amount.

[R2] OECD, « Private Pension Outlook 2008», 2009 (1)

This new OECD edition responds to the growing importance of the private pension systems within the landscape of retirement income provision. It highlights the necessity of complementary private provisions for individual long-term savings. Furthermore it analyses the implication of the financial crisis on the design of defined benefit contribution plans including default investment strategies. The chapter on Luxembourg

is relatively short but contains relevant key information on the specific sector, which, even in Luxembourg, is relatively difficult to obtain in such a condensed manner.

[R2] OECD, « Pensions at a Glance 2009 – Retirement Income Systems in OECD countries», 2009 (3)

The OECD edition "Pensions at a Glace" provides a useful updated comparative overview on pension systems and policy trends in the OECD. This 2009 update analyses in a special chapter the implications of the financial and economic crisis on pension systems. Considering the fall in value of investments by 23% (in 2008), pension funds were hit very hard. Declined outputs, rising unemployment and stagnation or declines in wages led to both lower income through contributions and higher expenditure. The report furthermore evaluates various government actions to mitigate the impact of the crisis, encompassing among others economic stimulus packages, labour market measures, regulation of private funds, etc. It also looks at recent pension reforms with regard to the coverage and adequacy of retirement benefits, improving financial sustainability as well as strengthening the administrative efficiency and the security of retirement income. As conclusions, one can draw from the report that the diversity of pension provisions remain the best way to deliver security in old age, and also that the huge negative impact of the financial turmoil on especially private pension plans is not considered sufficient to promote replacing them with public provisions. As the country profiles are based on 2006 information only, this part is more useful as a compilation of core country specific pension system features than as an adequate data source.

[R5] AXA, « Baromètre AXA de la retraite 2009: Étude sur le comportement des résidents luxembourgeois face à l'épargne et la retraite », *November 2009*

"AXA retirement barometer 2009: Study on the savings and retirement behaviour of Luxembourg residents"

The AXA barometer on pensions is an international conducted survey based on a 20-minute telephone interview with a representative population from Luxembourg (505 people) selected according to age, gender and place of residence, as well as composition and main source of family income. Conducted in 27 different countries it allows a comparison of public opinions and reported experiences related to pensions. The 2009 report is limited to the annotated poll results, which are presented as PowerPoint presentations in the forms of graphs and Tables, of which some are comparative to the 2007 results. Further explanations are provided extremely sparingly. The 2009 report is much shorter and differs somewhat from the previous one. For example, this year, it does not offer any international comparison. Nevertheless, it is an interesting source of information about the public's opinion with regard to retirement.

[R5] GUIGOU, Jean-Daniel, LOVAT, Brunoand SCHILTZ, Jang, « Les retraites au Luxembourg: modélisation et evaluation d'un système diversifié avec répartition et capitalisation », Luxembourg, February 2010

"Pensions in Luxembourg: modelling and evaluating of a system, diversified by redistribution and capitalisation "

This actuarial study analyses, for Luxembourg, the sustainability of the pure PAYG pension system in comparison to a mixed system with a larger share of capitalised pension components. In contrast to the highly dependency of the PAYG system on the demographic development, the study shows a sustainability gain for all income groups for a capitalised pension plan, assuming a ten% saving rate. The less progressively income develops during the working career, the higher the expected sustainability gain.

[H] Health

[H1] CES (CONSEIL ÉCONOMIQUE ET SOCIAL), « Évolution économique, sociale et financière du pays 2009 », Annual assessment 2009, April 2009
"Development of the country's economic, social and financial situation in 2009"

The 2009 assessment of the Economic and Social Council is a comprehensive impact analysis of the current crisis on the country. Growing unemployment is the major concern for the council, harbouring the risk of a future social crisis. It harshly criticises the deterioration in practices in the capital market, and recalls the importance of Luxembourg's social model. Recommendations are formulated for enlarging diversification in the financial sector as well in the real economy, where it focuses on logistics, environment and health. The assessment addresses the health care system in particular. It acknowledges on the one hand the outstanding quality of the services, but on the other it reminds about costs tending to get out of control. It favours investments in prevention and maintenance and gives no clear opinion as to whether or not a two-tier medical system does more harm or more good to the country.

[H1] THOMSON, Sarah, FOUBISTER, Thomas, MOSSIALOS, Elias. « Financing Health Systems in the European Union : Challenges and policy responses », WHO, European Observatory on Health Systems and Policies, Denmark, 2009

The scientific review on health financing and health economics in Europe was commissioned by the European Parliament. Against the background of the finance and economic crisis in Europe, the authors put a particular emphasis on sustainability of health care systems, which is further divided into economic and fiscal sustainability. Thus, it directs decision-makers'attention towards keeping the balance between labour market and GDP development on the one hand and the related costs of health care on the other, as well as between perceived public needs in health care and real requirements. It furthermore proposes various strategies to increase the sources of income for health care systems and to adjust the level of expenses to an acceptable level. Theses strategies consists of centralising public health insurance and purchasing power, allocating resources in a risk-adjusted manner, improving transparency and quality of care and searching for new contribution bases apart from labour income. The section on Luxembourg is relatively short and of limited information.

[H2] BECKER, Amélie, « De l'Assurance-Maladie à l'Assurance-Santé au Grand-Duché de Luxembourg : Pourquoi la création d'une Caisse Nationale de Santé ? », in : Bulletin luxembourgeois des questions sociales, Vol. 26, 2009, pp. 31-79
"From Sickness Fund to Health Fund of the Grand-Duchy of Luxembourg: Why the creation of a National Health Fund?"

Encouraged by the change of name of the Luxembourg former "Sickness Fund" to "Health Fund" the authors takes the initiative to analyse the political motivation of this choice and its impact on the future role of the health fund and potential judicial consequences related to a mission that is officially guided towards prevention. The article furthermore looks into the legitimacy of the public health insurance fund to act as a promoter of prevention, and analyses the current shared competence with the Directorate of Health. It concludes with imaginable future missions of the insurance scheme, and asks what mandate the government wants to give to the health insurance in this respect.

[H2] FORUM für Politik, Gesellschaft und Kultur, « Personalisierte Medizin», No. 290, Luxembourg, October 2009
"Personalised Medicine"

This edition of a national sociopolitical magazine covers the topic of biomedicine, an emerging branch of research and industry in Luxembourg. Various articles examine the subject from its historical development via the current and future scientific approaches and expected economical and labour market impacts, to ethical viewpoints and questions of data protection. It is a very interesting compilation on this topic which is still little discussed in the general public debate.

[H3; L; R2] IGSS (INSPECTION GÉNÉRALE DE LA SÉCURITÉ SOCIALE), « Rapport général sur la sécurité sociale 2008 », November 2009
"General report on social security 2008"

The general report on social security is the annual reference document on all aspects of social security. The predominantly key statistical information on all Social Security branches is enriched with plenty of explanation and detailed evaluation. It contains chapters on the covered population, health insurance, long-term insurance, pensions, occupational accident, family allowance and social inclusion. The entire statistical report is only available online, where the general report is also made available on: www.statsecu.etat.lu.

[H4] CONSBRUCK, Roger, « Panorama du système de santé luxembourgeois en 2009 », Rapport d'étude, Ministère de la Santé, 2009
"Panorama of the Luxembourg health care system in 2009 - Study Report"

The report provides a short but comprehensive overview of the current health care system in Luxembourg. It glances at the history, the legal framework, relevant actors and procedures as well as its financing system. For its length, the report provides a nearly exhaustive overview on relevant legislation as well as the number, specialties and distribution of medical professionals.

[L] Long-term care

[L] KERSCHEN, Nicole, « La difficile reconnaissance de l'aidant dans l'assurance-dépendance luxembourgeoise », in : Bulletin luxembourgeois des questions sociales, Vol. 25, 2009, pp. 145-172
"The difficult recognition of the caregiver in long-term care insurance in Luxembourg"

The article is part of an international study on the status of caregivers in various European countries. With this particular focus, this Luxembourg country report covers the short history of the long-term care insurance from its beginning in 1998 and analyses in particular the intention of the 2005' reform. The role of the caregiver depends very much on Luxembourg's priviledged concept of autonomy of the dependent person, who will be supported where necessary by professional and informal caregivers.

5 List of Important Institutions

Association des Médecins et Médecins-Dentistes (AMMD) - Association of Physicians and Dentists

Contact person: Jean Uhrig (President)
Adress : 29 rue de Vianden, L-Luxembourg
Webpage : www.ammd.lu

The AMMD is a professional association with the aim of protecting the financial interests and needs of the medical and medico-dental society at ministerial and parliamentary level and against the health insurance and the Inspection Générale de la Sécurité Sociale (IGSS), in particular with respect to the tariffs of the nomenclature.
Publications: Le Corps Médical, Bulletin, Volumes 2010

Caisse Nationale d'Assurance Pension (CNAP) - National Pension Fund

Contact person: Robert Kieffer (President)
Address: 125 route d'Esch, L-2096 Luxembourg
Webpage: www.secu.lu

Based on the act of 13 May 2008, the National Pension Fund (CNAP) was created in 2009 as a merger of four former pension schemes. It manages the public pension fund for old age and disability for all private sector employees. Its main tasks are to administer the individual pension benefit records, to calculate the pensions according to the pension formula and to make all pay-outs of pension benefits.

Caisse Nationale de Santé (CNS) - National Health Insurance Fund

Contact person: Jean-Marie Feider (President)
Address: 125, route d'Esch. L- 1471 Luxembourg
Webpage: www.cns.lu

The National Health Fund (CNS) is a public institution established by the law of 13 May 2008 and is part of the public social security system. It is responsible for the organisation and management of sickness and maternity in Luxembourg as well as for the management of the long-term care insurance. It decides on the offer of benefits, contribution rates for health insurance and long-term care insurance. As a negotiating partner for all health care providers, it negotiates agreements, rates and budgets.

Cellule d'évaluation et d'orientation de l'assurance dépendance (CEO) - Assessment and Orientation Unit of the long-term care insurance system

Contact person: Nathalie Rausch (Director)
Address: 125, route d'Esch, L- 1471 Luxembourg
Webpage: http://www.mss.public.lu/dependance/index.html

The CEO is a public service under the authority of the Minister with responsibility for social security, with the mission of assessing the state of dependency and establishing a care plan integrating the assistance and care required by the dependent person. It may also, where appropriate, propose corrective measures and rehabilitation. Furthermore the CEO is also responsible for monitoring the quality and adequacy of services provided to meet the needs of the dependent person.

Centre d'Etudes de Populations, de Pauvreté et de Politiques Socio-Economiques (CEPS/INSTEAD) - Research Centre on Populations, Poverty and Socio-Economic Policies

Contact person: Pierre Hausman (Director)
Address: 44, rue Emile Mark, L-4620 Differdange
Webpage: www.ceps.lu

CEPS/INSTEAD is a research institute specialised in economic and social sciences. The main activities are:

- *studies on population, poverty and socio-economic affairs*
- *development and comparable analyses of large-scale scientific databases nationally*
- *research on Luxembourg's social security system (solidarity, personal responsibility, social security)*
- *developing analytical tools for modelling and simulating of socio-economic scenarios*
- *conducting statistical, econometric, geographic and cartographic analysis*
- *providing postgraduate training programmes*

Publications:

- *Publisher and editor of the scientific journal Population & Emploi*
- *Évolution et place des femmes sur le marché du travail*
- *Multiple publications on labour, health, social inclusion, housing, etc.*
- *Bodson, Segura:, Le divorce au Luxembourg en droit et en chiffres, 2010*
- *Genevois : Zoom sur les retraités au Grand/Duché, 2009*
- *Clément : La "flexicurité" : définitions et applications au Luxembourg. 2009*

Chambre des Salariés - Chamber of employees

Contact person: Réné Pizzaferri
Address: 18, rue Auguste Lumière, L – 1012 Luxembourg
Webmail: www.csl.lu

The Chamber of Employees is the representation of the employees in the social dialogue. It also performs an advisory function to the government and all publicly managed organisations. The government is obliged to seek the opinion of the Chamber of Employees on all draft laws and regulations affecting interests of workers, the bill of the public budget as well as all issues concerning the creation and amendment of collective agreements.
Publications: Viabilité à long-term du système de pension – Eléments de reflexion, 2010

Commissariat aux Assurance - Supervision Authority of Insurance Institutions

Contact person: Victor Rod
Address: 7, boulevard Royal, L – 2449 Luxembourg
Webpage: www.commassu.lu

This is a public institution under the authority of the Minister for Treasury and Budget. The Commissariat is responsible for the approval of insurance, reinsurance and insurance intermediaries as well as for developing common standards on the international level and drafting laws and regulations for the insurance sector.

Confédération des organismes prestataires d'aides et de soins (COPAS) - Confederation of providers for aid and care

Contact person: Michel Simonis (President)
Address: 4, rue Jos Felten, L-1508 Howald
Webpage: www.copas.lu

COPAS is the association of the major long-term care providers. In 2008, it counted 18 members representing all types of nursing care institutions. It defends the members' interests in negotiations with public authorities to negotiate the remuneration fee (valeur monétaire)

from the long-term care insurance scheme, or subsidiarily with trade unions on collective labour agreements.

Centre de Recherche Public – Henri Tudor (CRP-Henri Tudor) - Public Research Centre in the field of ICT, environmental and health care technologies

Contact person: Pierre Plumer (Head of Department)
Address: 2A rue Kalchesbrück, L-1852 LUXEMBOURG
Webpage: www.santec.lu

The mission of the Public Research Centre Henri Tudor (engineer, who invented Tudor batteries) is to strengthen the economic and social fabric of the Grand Duchy of Luxembourg. It targets a large variety of sectors from services, through finance, production and construction, to health care and social security. The department CR SANTEC is the resource Center for Health care Technologies. Its primary objective is to help health care professionals to better focus their activities on the patient by implementing efficient solutions and tools. Its research and development projects concern:

- *CARA - National Electronic Medical Imaging Record (see report)*
- *eSante - Analysis & Feasibility Study for eHealth (see report)*
- *HealthNet - National secure health care ITC infrastructure (see report)*
- *ISIS - Inventaire des Systèmes Informatiques de Santé (see report)*
- *CIP - Clinical Information and Performance on patient's follow-up*
- *Dose DEO (reference dose level in Computer Tomography)*
- *GECAMed - Free & Open Source Application on medical records, electronic prescription and billing for medical practices*
- *ImageMed - RIS-PACS infrastructure for all medical imaging*
- *LABO - Electronic Exchange of Laboratory Results*
- *Mammo - Digitalisation of the National Breast Cancer Screening Programme*
- *Optimage - Optimal Image Quality for Modalities to facilitate control in radiology*

Publications:

- *Toward the Implementation of Integrated eHealth Solution: the Luxembourgish Experience, Med-e-Tel, Luxembourg, 2010*
- *Benefits of a National Electronic Radiological Record, Med-e-Tel, Luxembourg, 2010*
- *IT infrastructure for National Electronic Health Records in Luxembourg – Acceptance occurs when benefits outweigh disadvantages, Med-e-Tel, Luxembourg, 2010*
- *A Rule-based Language for Expressing Patient Electronic Consent, Proceedings of the Second International Conference on eHealth, Telemedicine, and Social Medicine (eTELEMED 2010), IEEE Computer Society, St. Maarten, (Netherlands Antilles), 2010*
- *The CARA Approach for Long-Term Preservation and Exploitation of Medical Images and Reports, ERCIM News n°80, 2010*

Centre de Recherche Public de la Santé (CRP - SANTÉ) - Public Research Centre for Health

Contact person: Marie-Lise Lair-Hillion (Head of Department)
Address: 1A-B, rue Thomas Edison, L-1445 Strassen
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The CRP-Santé is a public institution performing basic, pre-clinical and clinical research in biomedicine and health care. A second mission is to promote public health through evaluation and information campaigns, to perform studies on health care financing and advise Luxembourg authorities on health issues. CRP-Santé also encourages the debate between professionals and the general public in areas of Biomedical Research and Public Health. CRP-Santé delivers academic training and higher education in close collaboration with

major European universities and with the University of Luxembourg. It consists of six departments: Public Health; Clinical and Epidemiological Investigations; Virology, Allergology and Immunity; Immunology; Oncology; and Cardiovascular Diseases. Challenges for society: through its research activities, CRP-Santé generates new knowledge and technological innovations that will foster economic activities in the biotechnology sector. Publications (of the Department of Public Health):

- *Réseau transfrontalier de santé mentale : Première esquisse des apports et des limites de la sociologie des organisations, 2009*
- *Proposition d'un mode de surveillance du diabète au Luxembourg : Analyse de deux modèles de recueil de données, National Report, 2008*
- *Le diabète au Luxembourg: état de la situation à partir de données medico-administratives, Enjeux Santé, 2008*
- *Registre national du cancer : rapport de l'étude de faisabilité sur sa mise en place au Luxembourg, 2008*

Entente des Hôpitaux Luxembourgeois (EHL) - Luxembourg Hospital Association

Contact person: Marc Hastert (Director)
Address: 5, rue des Mérovingiens, L- 8070 Bertrange
Webpage: www.ehl.lu

The EHL represents the providers of in-patient health care (hospitals and clinics and long-term care facilities). The association aims to defend the interests of its members and to channel all forms of progress in hospital care to improve the hospitals' competition and the well-being of the patients.

Fondation "Stëftung Hëllef Doheem" - Foundation: Help at home

Contact person: Pierette Biver (Director of Care Services)
Address: 50, avenue Gaston Diderich, L-1420 Luxembourg

With over 1,000 employees, Hëllef Doheem is not only the largest ambulatory care provider in Luxembourg, but among the biggest employers in Luxembourg. Hëllef Doheem currently supplies services to more than 5,000 patients, fully or partly covered by both health and long-term care insurance. The organisation plays a very active role in the development of care concepts and applied research.

Inspection Générale de la Sécurité Sociale (IGSS) - General Inspectorate of Social Security

Contact person: Dr. Raymond Wagener (Head of Department)
Address: 26, rue Sainte Zithe L-2763 Luxembourg
Webpage: www.mss.public.lu

Under the authority of the Ministry of Social Security, IGSS is entrusted with

- *development of legislation and regulations on social security;*
- *control of social institutions under government responsibility*
- *which under the laws and regulations is vested in the government*
- *actuarial analysis of pension and health systems*
- *collection of the necessary statistical data both nationally and internationally*

IGSS is further responsible for the supervision of the supplementary pension schemes as well as the assessment of applications to receive nursing care benefits. The latter service, Cellule d'évaluation et orientation (CEO) is attached to IGSS. On an international level, IGSS acts as the reference institution for social security issues related to cross-border aspects. Publications:

- *Rapport général sur la sécurité sociale 2008, November 2009, www.statsecu.etat.lu*
- *Bulletin luxembourgeois des questions sociales, Volumes 25-26, 2009*

Ministère de la Santé - Ministry of Health

Contact person: Mars di Bartolomeo (Minister)
Address: Allée Marconi, Villa Louvigny, L - 2120 Luxembourg
Webpage: www.ms.etat.lu

The Minister of Health is responsible for the definition and implementation of health policy, monitoring of the implementation of laws and health regulations, supervision of institutions and health services. The supervision of health services is ensured by the Directorate of Health.

Publication: Panorama du système de santé luxembourgeois en 2009, Ministère de la Santé, Study Report, 2009

Service central de la statistique et des études économiques (STATEC) - Central service for statistics and economic studies

Contact person: Jean Langers (Head of Department)
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Webpage: www.statec.lu

STATEC is responsible for collecting as well as for analysing and modelling data to better understand phenomena of an economic and social nature. It is a scientific and administrative independent statistical office, which collects and computes data in areas ranging from production of goods and services to social cohesion and (un)employment, prices and wages, innovation and entrepreneurship. Statec is further involved in micro and macroeconomic forecasts, partly undertaken for third parties.

Publications:

- *Economie et statistiques*
- *Cahiers économiques*
  - *No. 109, Travail et cohésion sociale au Luxembourg, Rapport 2009*
  - *No. 108, La société luxembourgeoise depuis le milieu du 19e siècle dans une perspective économique et sociale, 2009*

Union des Enterprises Luxembourgeoises (UEL) - Union of Luxembourg Enterprises

Contact person: Pierre Bley c/o Chambre de Commerce
Address: 7, Rue Alcide de Gasperi, Luxembourg
Webpage: www.uel.lu

UEL is the non-profit umbrella organisation of employers, In the social dialogue it defends the convergent interests of businesses and employers. The composition of the UEL bodies reflects the economic sectors that it represents. Working groups are established on a permanent basis covering topics including legislation, overtaxation, economic studies, education and training schemes, environment and land use. The UEL also serves as a forum for topics concerning the European Union.

Publications:

Regular publication of position papers on various topics.

La réforme du régime général d'assurance pension –Position Paper of UEL, July 2009

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en