Luxembourg

Health Care & Long-Term Care Systems

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Health care systems

1.18. LUXEMBOURG

General context: Expenditure, fiscal sustainability and demographic trends

General country statistics: GDP, GDP per capita; population

GDP per capita (63,577 PPS in 2013) of Luxembourg is the highest in the EU. Despite decreasing significantly since its peak in 2007 (72,780 PPS), it remains more than double of the EU average of 24,600 PPS. Economic output is expected to continue growing significantly faster than the euro-area average. During 2015, Luxembourg's economy was expected to register positive growth of 4.7%, which is expected to continue by 3.8% in 2016 and by 4.4% in 2017 ([179]). Currently, the population is 0.5 million and projected to more than double by 2060, reaching 1.1 million.

Total and public expenditure on health as % of GDP

Total expenditure on health as a percentage of GDP (7.1% in 2013) is below the EU average (10.1% in 2013) and has decreased over the last decade, though with fluctuations, from a level of 8.2% in 2004. Public expenditure on health as a percentage of GDP has followed the same path, and is with 5.9% both below the EU average and its value in 2004 (7.8% and 7% respectively). However, when expressed in per capita terms, both total and public expenditure (5,091 PPS and 4,260 PPS in 2013) are well above the EU average (2,988 PPS and 2,208 PPS in 2013).

Expenditure projections and fiscal sustainability

As a result of population ageing ([180]), health care expenditure is projected to increase by 0.5 pps of GDP (below the average change in the EU of 0.9 pps in the "AWG reference scenario"). When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 0.8 pps of GDP from now until 2060 (EU: 1.6) ([181]).

Sustainability risks appear to be low in the medium-term from a debt sustainability analysis perspective due to the low level of debt at the end of projections (2026). However, in the long run, Luxembourg faces medium risks to fiscal sustainability. These risks are entirely driven by the necessity to meet future increases in ageing costs (notably pension and long-term care expenditure) ([182]).

Health status

Life expectancy (83.9 for women and 79.8 for men in 2013) and healthy life years at birth (62.9 for women and 63.8 for men in 2013) are all above the EU average and have overall increased over the last decade, although the trend seems to be inverted in recent years for healthy life years, both for women and men ([183]). Mortality is mainly due to cardiovascular diseases, cancers, ischaemic heart, cerebrovascular and respiratory diseases. ([184]) Transport accidents are slightly above the EU average, but broadly in line with it and death due to intentional self-harm is lower compared to EU average. In addition, infant mortality is amongst the lowest of the EU thanks to comprehensive and free antenatal and postnatal services. Amenable mortality, mortality rates which are thought avoidable if appropriate and timely care is delivered, is below EU average (in 2011, 116 vs 128.4 at EU level). As for the lifestyle of population, an increasing trend in the share of overweight population seems to have characterised Luxembourg in the past years. On the contrary, alcohol consumption has been decreasing over the past decade and so has the share of regular smokers. Programmes to prevent obesity through healthy eating and sports have already been launched, especially among young and children, and, paired with other existing initiatives to promote healthy behaviours, such as regulations on

([179]) European Commission (2016), European Economic Forecast Winter 2016.

([180]) I.e. considering the "pure ageing scenario" of the projections (see The 2009 Ageing Report at: http://ec.europa.eu/economy_finance/publications/publication14992_en.pdf).

([181]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([182]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

([183]) Data on life expectancy and healthy life years is from the Eurostat database.

([184]) Health Systems in Transition, HiT in Brief Luxembourg, WHO (2015).

alcohol advertising, they should be further expanded ([185]).

System characteristics

Overall description of the system

In 2013, about 83.7% of total health expenditure was public expenditure (statutory insurance contributions and taxation), about 10.8% was out-of-pocket spending and the remaining 5.6% mainly came from voluntary private health insurance.

Compulsory health insurance ([186]) is provided and managed by the National Health Insurance (Caisse Nationale de Santé, CNS), which was created by merging multiple sickness funds into one single payer in 2009. The CNS is obliged to maintain a reserve between 10% and 20% of the total planned expenditure ([187]).

The health insurance is mainly financed by contributions. Contributions are equally split between employers and employees, which are calculated as percentage of gross-income ([188]). Different rules apply to the self-employed and specific professions. The central government participates by paying 40% of the contributions. If gross-income does not exceed a certain level, no contributions have to be paid as a means to support low income or disadvantaged groups.

Coverage

Luxembourg's health care is based on a very comprehensive compulsory health insurance package. In 2012, 97.2% ([189]) of all citizens and registered residents were covered by the statutory health insurance system. Further, the system covers a high number of cross-border workers and their family members.

Administrative organisation

Health system regulation is a shared responsibility of the Ministry of Health and the Ministry of Social Security, which cooperate regarding the organisation, legislation and financing of the system. The Ministry of Health focusses on the planning and organisation of health care service delivery, enacting laws and regulations applying to health providers and directly co-finances public health programmes. It is further responsible for the determination of the national hospital plan and the scope of work of health care professionals. The Ministry of Social Security defines social policy and oversees the public institutions funded by the health, accident and long-term care insurance schemes. Public expenditure on health administration and health insurance as a percentage of GDP (0.1%) is below the EU average (0.47%). Public expenditure on health administration and health insurance as a share of total current health expenditure is also below average with 1.5% recorded for 2012 (vs. EU average 4.9% in 2013).

Role of private insurance and out of pocket co-payments

A low level of cost-sharing applies to many services. A higher level of cost-sharing applies to glasses and contact lenses, dental care and dental prostheses. Cost-sharing exemptions apply for people where the amount of cost-sharing exceeds 2.5% of the gross-income. In fact, out-of-pocket spending accounts for only a small part of private expenditure and decreased over the last decade (10.8% of total health spending which is less than the EU-average of 14.1%, after a decrease during the last decade from a level of 13.3%). Additional voluntary private insurance is taken up by around 56% of the population to cover out-of-pocket payments and cost sharing (complementary insurance). Note, however, that voluntary private health insurance schemes only account for about 4.2% of total expenditure in 2011. As a proportion of total benefits reimbursed, the part of voluntary insurance remains then very low since the compulsory system reimburses a comprehensive set of services.

([185]) http://www.clep.lu/code-de-deontologie/.
([186]) The social health insurance comprises health care, long-term care and accident insurance
([187]) According to the OECD, Luxembourg scores 1 out of 6 in the OECD scoreboard due to the not very stringent budget controls. See Joumard, I., C. André and C. Nicq (2010), "Health Care Systems: Efficiency and Institutions", OECD Economics Department Working Papers, No. 769, OECD Publishing, p. 39. doi: 10.1787/5kmfp51f5f9t-en http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=eco/wkp(2010)25.
([188]) With a maximum limit of five times the minimum guaranteed income.
([189]) Health Systems in Transition, HiT in Brief Luxembourg, WHO (2015).

Types of providers, referral systems and patient choice

Primary care is provided by general practitioners (GPs) who are self-employed and mostly work in individual private practices. Specialist outpatient care is provided by self-employed individuals working in their own private practices and/or hospital.

In Luxembourg, the number of practising physicians per 100 000 inhabitants (281 in 2013) is below the EU average (344 in 2013). The number of GPs has increased, from 78 in 2005 to 86 per 100.000 inhabitants in 2013, which is higher than the average in the EU. To practise, physicians need an approval of their qualifications by the Ministry of Health but there are no legal barriers to limit the medical personnel as such, especially since the EU legislation on mutual recognition of medical qualifications has been introduced. Considering that the system remains quite attractive, the number of physicians practising in Luxembourg is expected to continue to increase even if the high proportion of physicians aged 45+ (68% in 2007), likely to retire in the short to medium term, will lessen this inflow. In comparison, the number of nurses per 100 000 inhabitants (1193) is one of the highest of the EU and there are 4.1 practising nurses per physician. The remuneration of nurses is indeed very attractive in Luxembourg, with a ratio of 1.4 to the average wage of the working population in Luxembourg.

Patients are free to register with a GP but GPs have no gate-keeping role: patients can directly consult specialists even in the case of common primary care. Patients have the right to choose their GP, specialist and hospital and there are no legal means to limit the volume of activity even if there are some limitations on the number of visits to more than one physician of the same speciality within a certain period of time. In this context of free choice, improving the availability and transparency of information about health care providers' activity and availability is essential to optimise the patients' choice. Finally, pharmaceuticals are exclusively distributed through pharmacies whose number is strictly controlled by the authorities.

Pricing, purchasing and contracting of healthcare services and remuneration mechanisms

Physicians are paid on a fee-for-service basis. There are no performance-related payment bonuses for example to provide incentives for cost-effective health promotion, disease prevention, or disease management. The fees for medical services are negotiated every 2 years between the National Health Insurance and representatives of health care professionals. Every health care provider has to be contracted with the CNS; and it is determined by law that they must adhere to the fees agreed upon.

Health care services in Luxembourg are organised based on a reimbursement system. Generally, the patient has to pay the costs in advance and submits the receipts to the CNS for partial or total reimbursement. Exceptions apply to hospital treatments as well as third party payment for disadvantaged groups.

Hospitals are financed by the National Health Insurance. Every two years, the government decides upon a global budget which is then divided annually by the health insurance between the hospitals. Hospitals ([190]) have autonomy to recruit their staff. The hospitals are encouraged to review their quality management regularly. These efforts have been undertaken by the CNS in order to improve quality and cost-containment; the activity is combined with a financial reward.

Hospital discharge rates per 100 inhabitants are below the EU average (13.2 vs 16.5 in 2013) for inpatients and decreased over the last ten years ([191]). Conversely, after increasing all through the last decade, day-case discharges per 100 000 inhabitants are above EU average (7,395 vs 7,031). The average length of stay (7.3 days in 2013) is above the EU average (6.3 days) but has been quite stable over the last ten years. This may partly be a consequence of a financing system based on global hospital budgets, which does not directly incentivise its reduction. To tackle this issue, in light of the relatively low bed occupancy rate, the current system based on the global budget could benefit from including some elements of activity-

([190]) http://www.legilux.public.lu/leg/textescoordonnes/codes/code_securite_sociale/code_securite_sociale.pdf#page=57.
([191]) Eurostat.

based reimbursement, to promote a more efficient use of resources.

Since 1995, for pharmaceuticals, patients must pay only the part of the costs to the pharmacy not being reimbursed by the health insurance. ([192])

The market for pharmaceutical products

Total expenditure on pharmaceuticals as a percentage of GDP ([193]) is well below the EU average (0.62% ([194]) vs. 1.44% in 2013) while consumption is around average.

Luxembourg imports all pharmaceuticals products at prices based on those used in the country of origin which normally is Belgium, Germany or France ([195]). Drugs are sold in pharmacies only. The counsellor's role of the pharmacist has been increased by encouraging the substitution of a drug by a cheaper one if they have the same qualitative and quantitative fundamentals. For this purpose, doctors and pharmacists have a list of exchangeable products. The CNS maintains a comprehensive list of drugs approved for reimbursement (positive list). There are three categories of reimbursement for pharmaceuticals for outpatient care, with reimbursement rates of 40%, 80% or 100%. Drugs administered at the hospital fall under hospital's budget and are thus free of charge for the patient.

Use of Health Technology Assessments and cost-benefit analysis;

The use of Health Technology Assessment appears to be limited in terms of the definition of the benefit basket.

Health and health-system information and reporting mechanisms;

Luxembourg has been quite active in this field in recent years and a number of projects have been established to monitor and collect health care data. The Luxembourgish government has adopted a national eHealth plan which envisages the establishment of a national eHealth agency and the introduction of an electronic health record, enabling the exchange and sharing of health data between health care professionals. The aim is to improve quality and performance of the system and to control the development of expenditure, especially by avoiding redundant tests and examinations. In the medium term, each patient will have a personal file containing administrative data and diagnostic data such as laboratories results, radiological data and medications register.

Health promotion and disease prevention policies;

Several programmes are in place in order to promote health, including breast cancer screening, smoking cessation, free contraception, prenatal and postnatal programmes, and flu vaccination. Further, the Ministry of Health supports school health programmes, vaccination programmes, healthy living programmes and the distribution of health education material.

Public expenditure on prevention and public health services as a percentage of GDP (0.13%) and as a percentage of total current health expenditure (1.9%) are well below the EU average in 2013 (0.24%).

Recently legislated and/or planned policy reforms

Facing the general economic crisis in Europe, the reform of the health system from 2010 ([196]) not only tried to tackle the negative effects of the crisis but provided also some structural changes in order to improve the quality of care and to rationalise expenditure.

Measures include the creation of the Cellule d'expertise médicale to review services and

([192]) Positive list of pharmaceuticals, reimbursement is possible only if on list Cf Art 22 CSS http://www.legilux.public.lu/leg/textescoordonnes/codes/code_securite_sociale/code_securite_sociale.pdf#page=57.

([193]) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 in the OECD System of Health Accounts. Note that this SHA-based estimate only records pharmaceuticals in ambulatory care (pharmacies), not in hospitals and that over the counter drugs are not included either.

([194]) Latest available figure is 2012.

([195]) When determining the price for products imported from outside Europe, the price of the product in Belgium, France and Germany is taken into account.

([196]) http://www.legilux.public.lu/leg/a/archives/2010/0242/a242.pdf#page=2.

medical devices proposed for introduction into the health benefit basket or the modification thereof. In addition, the possibility was introduced for patients, especially chronically ill persons, to choose a doctor as a reference point for their medical treatments and follow-ups. The GP organises the care path and manages the patients' medical records, for which the eHealth agency is responsible.

The standardisation of medical procedures and the organisation of hospital networks as well as a better coordination between primary and hospital care were actively supported to improve quality and efficiency. Further, policies promoting greater generic drug substitution (patients refusing the substitution proposed by the pharmacist have greater proportion of cost-sharing) have been introduced. Measures also included the introductions/strengthening of tools to monitor the quality of care and to increase transparency (at patient, hospital and physician level, as well as at the health insurance level). In particular, the law of 2010 scheduled the creation of an electronic patient file to be used in all health care sectors and containing all the information related to the health status of a patient.

For the legislative period 2013-2018 the government intends to strengthen health care promotion and prevention of diseases by integrating health questions in all policies ("health in all policies"). The ongoing growth of health care expenditure shall be aligned to the economic growth of the country.

The major new policy plans include:

- **creation of a Health Observatory**: preparing anonymous epidemiological data necessary for working out national action plans in order to fight diseases such as cancer, chronic or cardio-vascular diseases and the evaluation of measures taken in the context of national health policy;

- **creation of a health care fund**: revenues come from taxes on products and substances whose consumption badly influences health;

- introduction of a **DRG System ([197])** (tarification à l'activité) instead of the hospital budgeting system.

Challenges

The analysis above has shown that a range of reforms have been implemented in recent years – e.g. improvements regarding hospital efficiency, improved data collection and monitoring and the control of pharmaceutical expenditure – and which Luxembourg should continue to pursue. The main challenges for the Luxembourgish health care system are as follows:

- To improve the basis for more sustainable and efficient financing of health care in the future (e.g. considering additional sources of general budget funds), aiming at a better balance between resources and spending.

- To continue to enhance and better distribute primary health care services to improve effectiveness and efficiency of health care delivery. To continue to shift excessive capacity and activity of acute inpatient care towards ambulatory and outpatient care services, and strategically directing more resources towards providers of lower levels of care.

- To implement a monitoring of human resources in the health care sector that ensures a balanced skill-mix, that avoids staff shortages and that motivates and retains staff to the sector in the future. In addition, to consider enhancing financial and institutional incentives for health care professionals to provide adequate levels of services to patients based on quality indicators, performance-based reporting and payment bonuses.

- To increase the use of cost-effectiveness information, such as HTAs, in determining the basket of goods.

([197]) Diagnosis related group (DRG) is a patient classification system adopted on the basis of diagnosis consisting of distinct groupings. It is a scheme that provides a means for relating the type of patients a hospital treats with the costs incurred by the hospital. DRG are based upon the patient's principal diagnosis, ICD diagnoses, gender, age, sex, treatment procedure, discharge status, and the presence of complications or comorbidities.

- To improve the systems for data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted.

- Promote the use of the recently deployed eHealth tools including electronic patient records can help ensuring effective referral systems from primary to specialist care and improving care coordination between types of care.

- To foster public action in the area of health promotion and disease prevention on the basis of the defined public health priorities (diet, smoking, alcohol, lack of exercise), given the pattern of risk factors.

Table 1.18.1: **Statistical Annex – Luxembourg**

General context												**EU- latest national data**		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	26	28	30	33	37	38	36	40	42	44	47	9289	9800	9934
GDP per capita PPS (thousands)	64.3	67.5	66.0	69.2	72.8	69.6	62.3	64.4	65.8	63.3	63.6	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	0.4	3.0	3.6	3.3	4.9	-2.5	-7.3	1.2	-0.4	-2.4	-0.4	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	13.2	10.1	0.4	0.7	-8.0	5.2	2.4	-4.2	-4.2	-5.2	-1.5	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	7.7	8.2	8.0	7.8	6.8	7.3	8.1	7.7	7.4	7.2	7.1	10.4	10.1	10.1
Total current as % of GDP	7.1	7.5	7.1	6.7	6.2	6.7	7.6	7.2	6.9	6.8	:	9.8	9.6	9.7
Total capital investment as % of GDP	0.6	0.7	0.8	1.1	0.6	0.7	0.5	0.5	0.4	0.4	:	0.6	0.5	0.5
Total per capita PPS	3610	4125	4240	4567	4344	4726	4931	5002	5044	4932	5091	2828	2911	2995
Public as % of GDP	6.5	7.0	6.8	6.6	5.8	6.5	7.0	6.6	6.3	6.0	5.9	8.1	7.8	7.8
Public current as % of GDP	5.9	6.2	5.9	5.5	5.2	5.8	6.5	6.1	5.9	5.6	:	7.9	7.7	7.7
Public per capita PPS	2165	2387	2443	2489	2508	2703	2823	2837	2558	2730	:	2079	2218	2208
Public capital investment as % of GDP	0.6	0.7	0.8	1.1	0.6	0.7	0.5	0.5	0.4	0.4	:	0.2	0.2	0.1
Public as % total expenditure on health	84.2	84.9	84.9	85.2	85.6	88.4	86.7	85.8	85.4	83.4	83.7	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	11.5	12.0	12.5	11.9	12.1	12.0	11.9	11.5	11.5	11.5	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	98.7	98.8	98.7	98.2	97.9	:	:	:	97.2	96.9	96.4	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	13.3	12.8	12.9	13.4	10.3	10.1	9.9	10.2	11.2	11.6	10.8	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	502.1	504.5	506.6
Life expectancy at birth for females	80.8	82.4	82.3	81.9	82.2	83.1	83.3	83.5	83.6	83.8	83.9	82.6	83.1	83.3
Life expectancy at birth for males	74.8	76.0	76.7	76.8	76.7	78.1	78.1	77.9	78.5	79.1	79.8	76.6	77.3	77.8
Healthy life years at birth females	:	60.2	62.4	62.1	64.6	64.2	65.9	66.4	67.1	66.4	62.9	:	62.1	61.5
Healthy life years at birth males	:	59.5	62.3	61.2	62.3	64.8	65.1	64.4	65.8	65.8	63.8	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	81	69	65	66	63	59	61	57	116	103	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.9	3.9	2.6	2.5	1.8	1.8	2.5	3.4	4.3	2.5	3.9	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												**EU- latest national data**		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	1.96	2.02	1.90	1.74	1.62	1.65	1.91	1.75	1.67	1.68	:	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.00	:	:	:	0.00	0.15	0.17	0.15	0.15	0.19	:	0.18	0.18	0.19
Out-patient curative and rehabilitative care	2.08	2.26	2.14	2.05	1.98	2.15	2.42	2.35	2.20	1.92	:	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	0.78	0.78	0.73	0.68	0.66	0.68	0.75	0.69	0.66	0.62	:	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.17	0.17	0.16	0.16	0.16	0.15	0.17	0.17	0.16	0.16	:	0.31	0.31	0.32
Prevention and public health services	0.14	0.12	0.16	0.13	0.14	0.12	0.18	0.14	0.14	0.13	:	0.25	0.25	0.24
Health administration and health insurance	0.10	0.10	0.12	0.09	0.09	0.09	0.12	0.21	0.09	0.10	:	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	1.76	1.83	1.70	1.58	1.42	1.55	1.74	1.59	1.55	1.51	:	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.00	:	:	:	0.00	0.15	0.17	0.15	0.14	0.17	:	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.76	1.92	1.80	1.68	1.63	1.81	2.01	1.92	1.73	1.43	:	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.65	0.66	0.61	0.58	0.55	0.59	0.64	0.59	0.55	0.51	:	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.08	0.09	0.08	0.08	0.08	0.08	0.09	0.09	0.08	0.08	:	0.13	0.12	0.13
Prevention and public health services	0.13	0.12	0.16	0.13	0.13	0.12	0.18	0.14	0.13	0.13	:	0.25	0.20	0.19
Health administration and health insurance	0.08	0.08	0.08	0.08	0.07	0.08	0.09	0.08	0.08	0.08	:	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.18.2: **Statistical Annex - continued – Luxembourg**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	27.7%	27.0%	26.6%	26.0%	26.2%	24.7%	25.0%	24.3%	24.1%	24.8%	:	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	0.0%	:	:	:	0.0%	2.2%	2.2%	2.1%	2.2%	2.8%	:	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	29.4%	30.2%	30.0%	30.6%	32.0%	32.2%	31.7%	32.7%	31.7%	28.4%	:	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	11.0%	10.4%	10.2%	10.2%	10.7%	10.2%	9.8%	9.6%	9.5%	9.2%	:	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	2.3%	2.3%	2.3%	2.4%	2.6%	2.3%	2.2%	2.4%	2.3%	2.4%	:	3.2%	3.3%	3.3%
Prevention and public health services	2.0%	1.6%	2.2%	1.9%	2.3%	1.8%	2.4%	1.9%	2.0%	1.9%	:	2.6%	2.6%	2.5%
Health administration and health insurance	1.4%	1.3%	1.7%	1.3%	1.5%	1.3%	1.6%	2.9%	1.3%	1.5%	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	30.0%	29.4%	28.7%	28.5%	27.3%	26.6%	26.6%	26.1%	26.5%	27.0%	:	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	0.0%	:	:	:	0.0%	2.5%	2.5%	2.4%	2.4%	3.1%	:	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	30.0%	30.8%	30.4%	30.3%	31.3%	31.0%	30.7%	31.5%	29.5%	25.6%	:	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	11.1%	10.6%	10.3%	10.5%	10.6%	10.1%	9.8%	9.7%	9.4%	9.1%	:	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	1.4%	1.4%	1.4%	1.5%	1.5%	1.4%	1.4%	1.5%	1.4%	1.5%	:	1.6%	1.6%	1.6%
Prevention and public health services	2.2%	1.9%	2.7%	2.3%	2.5%	2.1%	2.8%	2.3%	2.2%	2.3%	:	3.2%	2.7%	2.5%
Health administration and health insurance	1.4%	1.3%	1.3%	1.4%	1.4%	1.4%	1.3%	1.3%	1.4%	1.5%	:	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	1.11	1.09	1.07	1.06	1.04	1.23	1.41	1.38	1.35	1.32	1.29	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	1.1	1.1	1.1	1.7	1.7	1.6	1.6	1.6	1.5	1.5	1.5	0.9	0.9	0.8
CTS per 100 000 inhabitants	2.7	2.8	2.8	2.8	2.7	2.7	2.6	2.6	2.5	2.4	2.2	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1
Proportion of the population that is obese	18.2	18.6	20.4	20.0	20.3	22.1	22.1	22.5	23.5	23.0	22.7	14.9	15.4	15.5
Proportion of the population that is a regular smoker	28.0	27.0	23.0	21.0	21.0	20.0	19.0	18.3	16.9	16.8	15.7	23.2	22.4	22.0
Alcohol consumption litres per capita	12.6	12.4	11.8	12.0	11.8	11.5	11.4	11.4	11.4	11.3	11.0	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	238	242	255	261	268	272	270	277	276	278	281	329	335	344
Practising nurses per 100 000 inhabitants	894	909	1097	1094	:	:	1112	1105	1127	1192	1193	840	812	837
General practitioners per 100 000 inhabitants	67	69	78	77	82	81	79	82	82	83	86	:	78	78.3
Acute hospital beds per 100 000 inhabitants	:	502	454	447	440	432	421	414	406	396	387	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	6.3	6.5	6.5	6.4	6.5	6.6	6.7	6.4	6.6	6.6	6.5	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	17.1	16.8	16.2	15.8	15.7	15.7	15.2	14.5	14.7	14.3	13.2	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	4,188	4,361	4,475	5,065	5,685	6,364	6,493	6,204	6,983	7,403	7,395	6368	6530	7031
Acute care bed occupancy rates	:	64.0	69.0	70.0	70.0	70.7	71.8	71.1	71.1	72.0	70.4	72.0	73.1	70.2
Hospital curative average length of stay	7.3	7.1	7.2	7.4	7.4	7.3	7.4	7.5	7.3	7.4	7.3	6.5	6.3	6.2
Day cases as % of all hospital discharges	19.9	20.8	21.7	24.5	26.9	:	29.9	30.0	32.2	34.2	35.9	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	4.6	4.6	4.7	4.8	5.0	5.1	0.5	0.9
AWG risk scenario	4.6	4.6	4.8	5.0	5.3	5.4	0.8	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	0.5	0.6	0.8	0.9	1.1	1.1	110.5	3.1

Sources: EUROSTAT, OECD and WHO

Luxembourg

Long-term care systems

2.18. LUXEMBOURG

General context: Expenditure, fiscal sustainability and demographic trends

Luxembourg has roughly half a million inhabitants, less than 1% of the EU population. It is with 2,586 km^2 the smallest Member State of the EU. Despite its limited population of 0.5 million inhabitants, Luxembourg achieves the highest GDP per capita with 63.6 thousand PPS in 2013, compared to a EU average of 27.9 thousand PPS. The population is projected to double in the next decades, reaching 1.1 million in 2060. In 2012 public expenditure on LTC was with 1.7% of GDP, above average compared to the overall EU (1.0% of GDP).

Health status

In 2013 life expectancy at birth for both men and women was respectively 79.8 years and 83.9 years and was above the EU average (77.8 and 83.3 years respectively). In the same year, the healthy life years at birth for both sexes were with 62.9 years (women) and 63.8 years (men) also higher than the EU-average (61.5 and 61.4 respectively). At the same time the percentage of the Luxembourgish population having a long-standing illness or health problem was significantly lower than in the Union as a whole (23.6% and 32.5% respectively) in 2013. The percentage of the population indicating a self-perceived severe limitation in its daily activities has been decreasing in the last few years, and was also lower than the EU-average (7.8% against 8.7%) in 2013.

Dependency trends

The trends for dependency are increasing for Luxembourg over the next 50 years, as indicated by the projections. The number of people living with health limitations is projected to rise from 0.03 million in 2013 to 0.09 in 2060, an increase of 182% compared to the EU value of 40% for that period. Similarly the share of the dependent group in the whole population is foreseen to increase from 5.8% in 2013 to 7.8% in 2060; however the corresponding change is broadly in line, slightly smaller, than the EU average over the same period (34% vs. the mean of 36%).

Expenditure projections and fiscal sustainability

The expenditure projections reveal a heightened requirement for spending in the future. ([413]) As far as demographic drivers are concerned, the AWG reference scenario forecasts public expenditure on long-term care as % of GDP to grow from 1.5 to 3.2. The projected rate for Luxembourg over the period 2013-2060, 116%, is higher than the EU average of 40%. The AWG risk scenario, which captures additional cost drivers to demographic and health-status related factors, projects an increase of bigger magnitude from 1.5% to 4.8% of GDP, an increase of 226%, higher than the EU average of 149%.

Over the long run, Luxembourg faces medium risks to fiscal sustainability. These risks are entirely driven by the necessity to meet future increases in ageing costs (notably pension and long-term care expenditures). ([414])

System Characteristics

Long-term care insurance was introduced in 1999 as a new pillar of the social security scheme in order to cover needs of assistance and care for activities of daily living. The law was mainly inspired by the long-term care set up in Germany; however the principle of classifying the dependent persons into three levels was not upheld for Luxembourg.

There is a political commitment to the longest possible provision of home care, and the LTC law is based on four principles: priority to home care, priority to benefits in-kind, priority to rehabilitation and prevention measures and continuity of long-term caregiving.

In 2005 a change in the law defining the long-term care system adjusted among others the benefits package and stressed the importance of quality of service by establishing a dedicated body.

([413]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([414]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

Administrative organisation

Benefits are granted to all persons covered by sickness insurance and, in addition, there is the possibility of voluntary insurance. Compulsory social insurance is financed by social contributions and by a State contribution, providing benefits to all persons recognised as being dependent, regardless of age, income or residence. Contributions to the long-term care insurance have to be paid at a rate of 1.4% on all earnings (including fringe benefits and capital) without any upper threshold.

The long-term care insurance also covers non-dependents. If a person is not technically classified as dependent, but needs assistance in the form of devices (e.g. wheelchair, walking frame) or a modification of the home (e.g. installation of a shower on one level) devices to support activities of daily living, these costs will be reimbursed.

The organisation of care insurance was entrusted to two bodies, namely the *Caisse Nationale de Santé* (CNS) and the *Cellule d'Évaluation et d'Orientation* (CEO).

The National Health Insurance (CNS) manages the long care insurance by managing the budget of the long term care insurance and by taking the decision about the care needed by LTC beneficiaries and defined by the *Cellule d'Évaluation et d'Orientation*.

The *Cellule d'Évaluation et d'Orientation* (CEO) is a public body under the authority of the Ministry for Social Security, and is in charge of assessing the needs in activities of daily living and the other long term care services and of designing care plans. Indeed, based on the assessment, it draws up a structured care plan providing the necessary assistance to those who request it, depending on which form of care is the most appropriate, be it home or institutional care. CEO is also responsible for quality monitoring and for ensuring that the provided services match the needs of the dependent person. Lastly, it also has the task of providing informing and advising to protected persons and the bodies concerned on prevention and care of dependent persons. CEO comprises three consultation bodies:

- the Advisory Committee, composed of government representatives, representatives of beneficiaries and providers, social partners and the CNS, which consults on the evaluation of activities run by the care insurance;
- the Commission performance, a consultative organ composed of government representatives, representatives of providers and of a healthcare expert proposed by the most representative association of patients, which develops guidelines and standards in particular in the quality of assistance and care, technical aids, adaptations to dwellings;
- the concerted action, which gathers to examine the functioning of the care, assistance and care networks and care and assistance establishments and propose improvements in the system. This brings together the ministers responsible for family affairs, health and budget or their representatives, organisations active in the fields of health, family and social action, and associations representing the beneficiaries of long-term care insurance.

Role of the private sector

Market entry to the care-giving sector is restricted to organisations approved by the Ministry of Family Affairs based on the fulfilment of certain quality standards and after adhesion to a framework contract with the National Health Insurance, which determines the rights and obligations for executing the nursing care services. The following types of care providers, mostly private, were registered by the end of 2014:

- 22 ambulatory networks offering nursing care at home;
- 52 day-care institutions;
- 40 intermittent-care centres for alternating short-term stays;
- 52 nursing homes and so-called integrated homes for elderly with a mix of dependent and less-dependent residents.

Eligibility criteria and user choices: dependency, care needs, income

Benefits under the dependency insurance are granted if the dependent person is in need of assistance and care for basic everyday activities for at least 3.5 hours per week and if his/her dependency condition is likely to last longer than 6 months or to be irreversible.

Co-payments, out of the pocket expenses and private insurance

The benefit package for long-term care is offered without any co-payment. If the beneficiary resides in an institution, the price of accommodation (board, lodging, basic domestic services, laundry, etc.) has to be paid by the resident([415]). The government provides means-tested financial support for those residents in nursing homes and integrated homes for the elderly whose own revenues do not allow to cover for accommodation and services costs (*accueil gérontologique*).

Formal/informal caregiving

Beneficiaries cared for at home can receive all care services that they are entitled to from professional carers (so-called in-kind services) or subcontract up to 10.5 hours per week to informal caregivers of their choice (generally a family member). Both types of service provision can be combined, which represents the most preferred type of care provision (used 69% of the home-care beneficiaries in 2014). Only activities of daily living and domestic tasks can be performed by an informal caregiver, whereas psychological support and counselling can only be offered by professional caregivers. In 2014, in-kind benefits for at-home care amounted to around EUR 137 million and cash benefits to around EUR 55 million.

There are no figures available on the exact number of informal caregivers; however in 2014, a total of 6,744 beneficiaries received cash benefits or cash and in-kind benefits (81.2% of at-home care recipients). The long-term care insurance furthermore takes over the costs for counselling of the informal caregiver. However, in 2014 only 296 persons received counselling activities. Secondly, if the informal caregiver does not benefit from a personal pension, the long-term care insurance can pay the pension contribution of the informal caregiver (2,940 recipients until 2014). ([416])

Prevention and rehabilitation policies/measures

Over the last years, the networks of home care services have implemented a new approach to better link acute and long-term care periods for the long-term care beneficiaries ("*infirmier de liaison ou infirmier relais*"). As ambulatory care providers, they run offices surrounding hospitals. They organise patients' transfers from hospital at home and inform them about continuity in caregiving between hospital and networks. The services are usually privately funded.

Recently legislated and/or planned policy reforms

The government program of 2009 announced a review of the operation and the financial sustainability of the long-term care insurance with a report published in 2013. Following its publication, highlighting the financial sustainability risks related to the current features of the nursing care insurance, the government has decided to reform the system to ensure long-term financial viability, focussing on enhancing cost-efficiency. The debate, both in Parliament and amongst stakeholders started in 2014.

As part of the 2013-2018 government programme, several activities are planned to support the revision of services as they are shaped, focussing on their effectiveness and current volumes. Major focus areas for revision are the assessments of degrees of dependence, the evaluation of the breadth of coverage and coordination between involved entities, including planning of activities and of service tariffs.

More specifically, the government set the focus on:

- simplification and standardisation of the evaluation process by combining LTC services and introducing flat-rates;

([415]) Introducing the concept of "Accueil gérontologique" (cf. http://www.legilux.public.lu/leg/a/archives/2004/0070/a070.pdf#page=2).

([416]) IGSS (2015), "Rapport général sur la sécurité sociale", Luxembourg.

- new reimbursement possibilities of the LTC services;

- redefining the roles of informal caregivers and cash services strengthening the link between services given and those covered;

- development of a transparent and effective quality policy and control.

In the short term, the 2014 Law setting State budget for 2015 financial year calls for a freeze of tariffs ([417]) at the 2014 level. In combination with the other health insurance measures ([418]), the expected gain from the budget measures within the *Zukunftspak* amounts to 3.5% of expenditures for services in kind in 2018.

Challenges

Luxembourg has a high quality system of LTC, with high levels of satisfaction among users but important future sustainability issues to tackle. The main challenges of the system appear to be:

- **Improving the governance framework:** to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC service; to establish good information platforms for LTC users and providers;

- **Improving financing arrangements:** to face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; to foster pre-funding elements, which implies setting aside some funds to pay for future obligations;

- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits and the scope of coverage, that is, setting the types of services included into the coverage; to provide targeted benefits to those with highest LTC needs;

- **Encouraging home care** to continue to monitor and evaluate alternative services, including incentives for use of alternative settings;

- **Ensuring availability of formal carers:** to seek options to increase the productivity of LTC workers;

- **Changing payment incentives for providers:** to adapt provider payments for LTC, including the nomenclature of nursing care services, and consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users;

- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC;

- **Improving value for money:** to encourage competition across LTC providers to stimulate productivity enhancements; to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to invest in ICT as an important source of information, care management and coordination;

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

([417]) Measure no. 256 of the New Generation Budget (BNG).
([418]) Measure no. 255 of the New Generation Budget (BNG).

Table 2.18.1: **Statistical Annex – Luxembourg**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	26	28	30	33	37	38	36	40	42	44	47	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	64.3	67.5	66.0	69.2	72.8	69.6	62.3	64.4	65.8	63.3	63.6	26.8	27.6	28.0	28.1	27.9
Population, in millions	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	1.2	1.4	1.4	1.4	1.3	1.4	1.6	1.6	1.6	1.7	:	1.0	1.0	1.0	1.0	:
Per capita PPS	635.7	753.8	757.2	810.0	810.5	866.1	871.2	896.9	944.7	1013.2	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	3.3	3.4	3.5	3.5	3.7	3.6	3.6	3.7	3.8	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	80.8	82.4	82.3	81.9	82.2	83.1	83.3	83.5	83.6	83.8	83.9	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	74.8	76.0	76.7	76.8	76.7	78.1	78.1	77.9	78.5	79.1	79.8	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	60.2	62.4	62.1	64.6	64.2	65.9	66.4	67.1	66.4	62.9	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	59.5	62.3	61.2	62.3	64.8	65.1	64.4	65.8	65.8	63.8	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	23.4	22.6	23.6	26.1	24.4	22.0	21.9	20.9	20.2	23.6	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	9.1	6.3	6.9	6.7	6.9	6.2	6.0	6.0	5.8	7.8	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	3	3	4	4	4	5	4	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	4	5	6	7	7	7	9	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.6	1.8	2.0	2.2	2.2	2.3	2.4	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	2	2	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.18.2: **Statistical Annex - continued – Luxembourg**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	26	28	30	33	37	38	36	40	42	44	47	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	64.3	67.5	66.0	69.2	72.8	69.6	62.3	64.4	65.8	63.3	63.6	26.8	27.6	28.0	28.1	27.9
Population, in millions	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	1.2	1.4	1.4	1.4	1.3	1.4	1.6	1.6	1.6	1.7	:	1.0	1.0	1.0	1.0	:
Per capita PPS	635.7	753.8	757.2	810.0	810.5	866.1	871.2	896.9	944.7	1013.2	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	3.3	3.4	3.5	3.5	3.7	3.6	3.6	3.7	3.8	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	80.8	82.4	82.3	81.9	82.2	83.1	83.3	83.5	83.6	83.8	83.9	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	74.8	76.0	76.7	76.8	76.7	78.1	78.1	77.9	78.5	79.1	79.8	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	60.2	62.4	62.1	64.6	64.2	65.9	66.4	67.1	66.4	62.9	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	59.5	62.3	61.2	62.3	64.8	65.1	64.4	65.8	65.8	63.8	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	23.4	22.6	23.6	26.1	24.4	22.0	21.9	20.9	20.2	23.6	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	9.1	6.3	6.9	6.7	6.9	6.2	6.0	6.0	5.8	7.8	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	3	3	4	4	4	5	4	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	4	5	6	7	7	7	9	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.6	1.8	2.0	2.2	2.2	2.3	2.4	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	2	2	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".