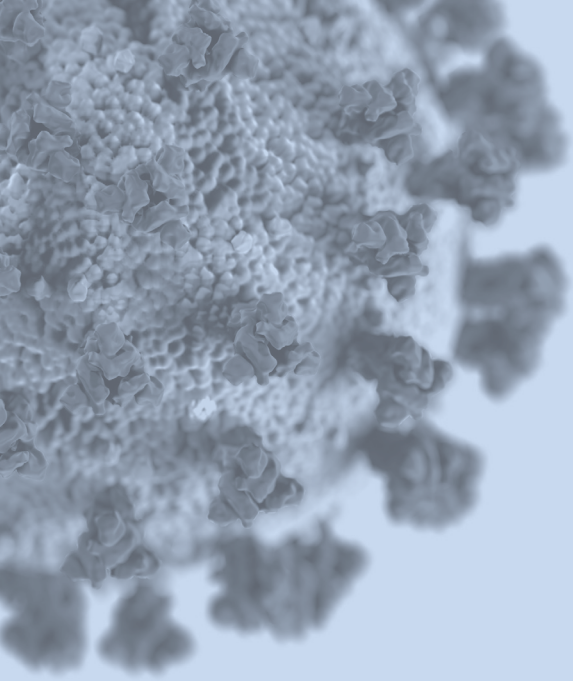

MC COVID-19

Governmental response to the COVID-19 pandemic in Long-Term Care residences for older people: preparedness, responses and challenges for the future

Luxembourg

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Contents

MC-COVID19
Coordination mechanisms in Coronavirus management between different levels of government and public policy sectors in 15 European countries

The political and administrative management of the healthcare crisis provoked by the COVID 19 is a key issue in preventing the spread of the disease. The Mc-COVID 19 project is set to analyse the socio-sanitary co-ordination procedures in the context of institutionalized older-age care (age group that appears particularly vulnerable in this epidemic context), in Spain as well as in the rest of the EU-15. This study focuses on the articulation of resources between health and social policies, and aim to contribute to improve the effectiveness of the decision-making process and crucial aspects in the fight against the pandemic. Findings also aim to be useful to inform other public policy sectors involved in crisis-related situations.

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1. DESCRIPTION AND ANALYSIS OF THE ROLE OF THE RESIDENTIAL CARE SECTOR FOR THE OLDER-AGE POPULATION IN LUXEMBOURG (PRE-COVID19)[1]

1.1. Trajectory of LTC until the most recent model

Compulsory long-term care (LTC) insurance, called "dependency insurance" (*assurance dépendance*), legally came into effect in 1999 with the law of 1998 (Grand-Duché de Luxembourg, 1998a), which was amended in 2005 (Grand-Duché de Luxembourg, 2005, and later in 2017 and 2018: see sub-section 1.2)[2]. The introduction of public dependency insurance recognised dependency as a new social security risk, similar to disease, work accidents and old age disability. The goal of dependency insurance is to provide compensation for the expenses generated through third-party assistance, to perform daily living activities. This applies not only to the needs of older persons, but also to the needs of disabled people.[3]

Affiliation to the dependency care insurance is mandatory and access to continuous insurance benefits is guaranteed from the first day of membership. Voluntary insurance is possible, for which a qualifying period of one year is applied.

To cope with the expenses, the dependency insurance applies the distribution with the establishment of a reserve system. This is essentially financed by three resources:

- A dependency contribution levied on the income of insured persons;
- An annual contribution from the State, currently set at 40% of the total expenses of the dependency insurance, including the working capital endowment (legal reserve); and
- An insurance licence fee from the energy sector.

The organisation of the long-term care insurance has been entrusted to two bodies, namely the National Health Fund (*Caisse Nationale de Santé - CNS)* and the Evaluation and Orientation Unit *(Cellule d'Evaluation et d'Orientation - CEO)*. The CEO was newly created and started its work of evaluating requests from dependent persons. During the initial phase, efficient procedures for assessing the needs of the applicants had to be developed. Another problem at this early stage was a lack of beds in care institutions and how to meet the needs for technical adaptations in the homes of dependent persons. As a public service placed under the authority of the Ministry for social security and attached to the Inspectorate General of Social Security ("*Inspection Générale de la Sécurité Sociale*" – IGSS), CEO's mission was to ascertain the level of dependency and establish a care plan incorporating the help and care required by the dependent.

The AEC is also in charge of: 1) Monitoring the quality of services provided and their adequacy in meeting the needs of dependents. 2) Informing and advising protected persons and bodies concerned with the prevention of addiction and the care of dependents.

1
This series of reports is one of the research results of the Mc-COVID-19 project, "MC-COVID19: Coordination mechanisms in Coronavirus management between different levels of government and public policy sectors in 15 European countries", funded by the Spanish National Research Council (CSIC) within the CSIC-COVID-19 programme, as well as of the GoWPER project, "Restructuring the Governance of the Welfare State: Political Determinants and Implications for the (De)Commodification of Risks", CSO2017-85598-R *Plan Estatal de Investigación Científica y Técnica y de Innovación*.

2
A global overview of the long-term care (LTC) insurance (Assurance dépendance) in Luxembourg can be consulted in IGSS (2019); Pacolet et al. (2018) may also be consulted as well as Directorate-General for Economic Affairs (2019). It exists also a practical guide to the LTC insurance before the 2017 reform (Ministère de la Sécurité sociale, 2009).

3
If not indicated otherwise, all data and figures in this section stem from IGSS (2020b).

In order to operate in the field of dependency insurance, service providers must practice either by virtue of an authorisation issued by the supervisory ministry, or by virtue of another legal provision. They must also adhere to the framework agreement negotiated between the CNS and the representative association of service providers or engage with the CNS through a service contract.

The representative organisation of care providers COPAS (*Confédération des Organismes Prestataires d'Aides et de Soins*) became the recognised collective bargaining party for the collective labour agreement with the long-term care insurance, obviating negotiations with each single care provider.

Entitlement and eligibility for the Luxembourg LTC system are neither income- nor asset-based. Age too is no criterion. The only requirement for entry into the system is the evaluation of needs done by the CEO. As a result of this evaluation, it determines the applicant's needs and translates them into a care plan, enumerating the different acts to be performed (and invoiced).

Long-term care insurance benefits can be classified under seven headings:

- aids and care for the essential acts of life, in the three areas of personal hygiene, nutrition and mobility;
- help with household chores;
- support activities;
- advice;
- the products necessary for aid and care;
- technical aids;
- accommodation adaptations.

A first modification of the law on long-term care was carried out in 2005 and came into force two years later, which further specified and slightly amended the benefit package. The different acts to be provided are converted into hourly durations.

The maximum duration of assistance is in principle set at 24.5 hours per week. In application of the law of 2005, which entered into force on 1 January 2007, the ceiling for essential acts of life can be increased from 24.5 hours to 38.5 hours for exceptionally serious situations. (IGSS, 2019)

Care is provided by a set of both community care and residential care providers, who practice by virtue of an authorisation issued by the supervisory Ministry after an accreditation process. On demand of the beneficiary, part or all the care may be provided by an informal carer. In this case, benefits in-kind are replaced with cash benefits. These are paid to the beneficiary who may conclude a contract with the informal carer and, in the case of a low amount of hours and hence of remuneration, this contract may be concluded following a simplified formula.

◂ back to table of contents

Providers may either be public or private, for-profit or non-profit; they need an accreditation by the supervisory Ministry.

1.2. Current arrangements in LTC

The law that newly introduced LTC insurance, called "dependency insurance" (*assurance dépendance*) in 1999 (see sub-section 1.1) was recently amended in 2017 and 2018 (Grand-Duché de Luxembourg, 2017a and 2018). The goal of dependency insurance did not change and neither did the guiding principles, which are: priority of rehabilitation on care; priority of home care on residential care, priority of in-kind over in-cash benefits and guarantee of the continuity of care.

With regard to the financing of LTC insurance, in 2017 the contribution rate was increased to 1.4% on (more or less) all earnings, without any upper threshold.

The AEC is also in charge of: 1) Monitoring the quality of services provided and their adequacy in meeting the needs of dependents. 2) Informing and advising protected persons and bodies concerned with the prevention of addiction and the care of dependents.

Keeping the dependent integrated within their family is guaranteed by providing increased attention for informal carers: assessing their contribution at the start; providing more respite care; providing yearly training and more regular follow-ups. The latter is aligned with the ambition to provide more frequent re-assessments, which should guarantee that the care plan is more adapted to the evolving needs of the dependent person.

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

With the 2018 reform, greater flexibility has been put in place with regards to daily life activities, through the introduction of flat-rate billing (instead of billing per provided acts) as well as changes in the organisation and time allocated for activities, support, domestic chores and counselling (replaced by independent support activities, coaching and home support activities) and the possibility of individual home care at night. In addition to these services, it also includes: help and care for daily life activities in the areas of personal hygiene, nutrition and mobility; products needed for help and care, technical aids and accommodation conversions.

On the issue of transparency, a new list of more detailed dependency and support categories was defined in 2017. Certain categories of support were redefined, to make the ambition of integration in the home setting more visible. The introduction of these 9 dependency categories was considered a reasonably flexible system, in particular since they are defined with a time bracket of a minimum and maximum numbers of hours. The scope of

back to table of contents

services was widened, with more time for guidance and social integration in addition to personal care and housekeeping.

Entitlement and eligibility for the Luxembourg LTC system are neither income- nor asset-based. Age too is no criterion. The only requirement for entry into the system is the evaluation of needs done by the AEC[4]. As a result of this evaluation, it determines in a summary of care (*synthèse de prise en charge*) the aids and care that the applicant needs and hence one of the 15 levels of care is assigned to the beneficiary. These 15 levels correspond to different time allocations for the provision of care, varying from 210 to 350 minutes per week for level 1 and more than 2,171 minutes per week at level 15, with an increase of 140 minutes per week for each successive level.

The need for care must be regular and represent a minimum of three and a half hours per week. The status of dependency must be irreversible or last for at least six months.

People who have been granted a decision by the CNS to benefit from palliative care, may also be beneficiaries of the dependency insurance for the provision of palliative care, without any evaluation of their care needs.

The AEC may, on own initiative or on demand of the beneficiary, decide to undertake a re-evaluation of the dependency situation, according to the deadlines laid down in the law (Grand-Duché de Luxembourg, 2017a).

The services provided and paid for by the dependency insurance include assistance for the basic activities of daily living (ADL, European Commission & Economic Policy Committee, 2018; in Luxembourg: *actes essentiels de la vie* – AEV) as laid down in Art.350 of the Code of Social Security (*Code de la Sécurité sociale* – CSS: IGSS, 2020a), for independence support activities and technical aid. In addition, in case of inpatient admission they include support activities in institutions (a flat rate of four hours per week by default). In the case of home care, they include guarding activities (a flat rate of seven hours per week for individual guarding, 40 hours per week for group guarding and ten nights per year for night watch), household maintenance assistance activities (a flat rate of three hours per week)[5], incontinence equipment, modification of accommodation, training for technical aids and the training of the informal carer (a flat rate of six hours per year).

1.3. Debates around the development of a LTC system

There is no debate in Luxembourg between institutionalisation and home care. Since the introduction of LTC insurance, one of the guiding principle is priority of home care on residential care. This principle is not being questioned.

Another principle is the priority of in-kind over in-cash benefits, the latter being disbursed to the beneficiaries but going at the end to informal carers.

4
During the time between the introduction of an application and the decision of the AEC, the dependency insurance covers a flat rate of 780 minutes of care per week.

5
The guarding activities and the household maintenance assistance activities belong to social care.

◂ back to table of contents

The informal carers are largely dominated by women (except for those aged 80+, see IGSS, 2020b) and with a growing employment rate of women, there may be less informal carers in future.

Other elements of the public debate include:

Since the launch of the debate on the recent reform of the long-term care insurance, trade unions were concerned about the maintenance of the care level for the dependent persons and the level of employment. In October 2015 e.g., the OGBL trade union proposed to increase the state contribution of 40% to the former level of 45%, to introduce employer contributions and even to increase the general contribution of all incomes. It warned also for lump sum reimbursement, instead of individual compensation schemes on the real allocated care time. They fear that the system will become less transparent and les controllable, which would be exactly the opposite of the ambitions of the new law.

The trade union LCGB could not agree with the new reform because of the announced austerity measures in the *'Zukunftspak'* (the future pact, Grand-Duché de Luxembourg, 2014; € -14.5 million in 2016 an € -38.5 million in 2017).

Remarkable is that in its forecast for the future expenditures, the reform law mentions: "The presented results refer only to the protected resident population, because the information about non-residents is insufficient." (p. 33).[6] We already highlighted in the country profile 2016, in spite of their very high number among the Luxembourg workforce.

The problem that only a limited amount on social spending for LTC goes to cross-border and other mobile workers, has been and remains a point of concern. The LCGB trade union mentioned the pending problem of 175,000 cross-border workers (among which 40,000 from Belgium), who contributed to the financing of the LTC insurance system from the very start, but only benefited from it in a limited way.

The trade unions also regularly bring up the discussion on whether the companies should participate in the financing of LTC insurance, or whether it should be financed entirely or predominantly from the state budget.

1.4. LTC governance

Since the last amendments on the LTC insurance, in 2017 and 2018 the mandatory affiliation is maintained, as well as the financing.

In 2017, the contribution rate was increased to 1.4% on (more or less) all earnings.

The representative organisation of care providers COPAS (*Confédération des Organismes Prestataires d'Aides et de Soins*) became the recognised collective bargaining party for the collective labour agreement with the

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

back to table of contents

long-term care insurance, obviating negotiations with each single care provider.

Total public spending on LTC in 2018 was €664.1 million, from which 43.5% were dedicated to home care, 50.3% to care in institutions and the other 6.2% for several kinds of expenses (administration costs, cash benefits, benefits abroad, contribution transfers, other expenses). Beneficiaries are not obliged to any co-payments for LTC, except lodging costs (accommodation and services like meals, basic domestic services, laundry etc.) in the case of residing in an institution. Beneficiaries who cannot afford to pay these costs may get a means-tested support from the National Solidarity Fund (*Fonds National de solidarité - FNS)* called "*accueil gérontologique*". This supplementary payment by the FNS is calculated in a way that for the beneficiary pocket money of €475.81 per month is safeguarded. In 2019, 615 persons benefited from this, to a total amount of €7.9 million (Ministère de la Famille, de l'Intégration et à la Grande Région, 2020*)*.

Care is provided by a set of both community care and residential care providers, who practice by virtue of an authorisation issued by the supervisory Ministry (currently the Ministry for Family, Integration and the Greater Region) after an accreditation process. On demand of the beneficiary, part or all the care may be provided by an informal carer, who has to be evaluated and recognised as capable of the role by the AEC. In this case, benefits in-kind are replaced with cash benefits. These are paid to the beneficiary who may conclude a contract with the informal carer and, in the case of a low amount of hours and hence of remuneration, this contract may be concluded following a simplified formula.

Care may be provided at the home of the beneficiary, or in institutions. There are 4 categories of care providers: 1) Help and care networks (*réseaux d'aide et de soins* – RAS, 22 networks as of the end of 2018); 2) Semi-stationary centres[7] (*centres semi-stationnaires* – CSSTA, 54 centres as of the end of 2018); 3) Continuous care facilities accommodating dependent people day and night and providing them all the assistance and care required for their degree of dependency (établissements d'aides et de soins à séjour continu – ESC, 52 centres as of the end of 2018); 4) Support and care establishments for intermittent stays[8] (établissements d'aides et de soins à séjour intermittent - ESI, 43 establishments as of the end of 2018). The first two incorporate care at-home; the latter two belong to the residential care sector. In 2018, 67.5% of the 14,209 beneficiaries were provided for in the home care sector and in ESI, whereas 32.5% of the beneficiaries stayed in ESC.

Providers may either be public or private, for-profit or non-profit; they need an accreditation by the supervisory Ministry.

There are no data available about the market shares of these 3 forms of providers. After comparing data of the IGSS, the CNS and COPAS, the market shares can be approximately defined as follows:

7
These could either be day care or night care centres; there are currently no night care centres in Luxembourg.

8
Equally accommodating dependent people day and night and providing them with all the assistance and care required according to their degree of dependency, but allowing an alternation between the stay in the centre and the stay in a private home. These category responds predominantly but not exclusively to the needs of people with disabilities.

◂ back to table of contents

Table 1: Estimated market shares of different forms of LTC providers, end 2018

Categories /Forms of providers	*public*	*for-profit*	*non-profit*
RAS	0.0%	25.0%	75.0%
CCSTA	12.5%	5.0%	85.5%
ESC	40.4%	9.6%	50.0%
ESI	4.5%	0.0%	95.5%

Source: own calculations using data from IGSS (2020b), CNS and COPAS (data collected by phone).

The total work force in the care sector, that was employed by the above mentioned providers, was 9,641 FTE (full-time equivalents, équivalent temps plein – ETP) at the end of 2018, of which 70.1% or 6,754 FTE were care workers; for the year 2017 these numbers are 9,485 and 6,702, and for 2016 they are 9,393 and 6,596 respectively. Amongst the employees of the different providers, 27.9% work for help and care networks; 4.5% work for semi-stationary centres, 56.1% for continuous care facilities and 11.5% for support and care establishments for intermittent stay.

There are only few data on the number of informal carers. It should be noted, however, that 7.6% of the dependency insurance expenses were paid in cash in 2018 and should have served to remunerate the informal carers. Moreover, statistics show that out of a total of 8,675 beneficiaries cared for at home, 1,270 opted for cash benefits and 5,006 have opted for a combination of cash and in-kind benefits, which gives a potential number of 6,276 informal carers. Another, although limited, insight in the prevalence of informal carers can be given by the fact that, between 1999 and 2018, the dependency insurance took over the social contributions to the pension insurance for 3,772 informal carers, as the law foresees this possibility. But obviously, not all informal carers have a contract and a salary, and not all are registered for pension insurance. Statistics for some of these workers show that the majority of them are women (72%).

1.5. General functioning of the residential care system

AEC's mission is to ascertain the level of dependency and establish a care plan incorporating the help and care required by the dependent. The AEC may, on own initiative or on demand of the beneficiary, decide to undertake a re-evaluation of the dependency situation, according to the deadlines laid down in the law (Grand-Duché de Luxembourg, 2017a).

In order to operate in the field of dependency insurance, service providers must practice either by virtue of an authorisation issued by the supervisory ministry, or by virtue of another legal provision. They must also adhere to the framework agreement negotiated between the CNS and the representative

◂ back to table of contents

association of service providers or engage with the CNS through a service contract.

The services provided and paid for by the dependency insurance include assistance for the basic activities of daily living (ADL, European Commission & Economic Policy Committee, 2018; in Luxembourg: *actes essentiels de la vie* – AEV) as laid down in Art.350 of the Code of Social Security (*Code de la Sécurité sociale* – CSS: IGSS, 2020a), for independence support activities and technical aid. In addition, in case of inpatient admission they include support activities in institutions (a flat rate of four hours per week by default). In the case of home care, they include guarding activities (a flat rate of seven hours per week for individual guarding, 40 hours per week for group guarding and ten nights per year for night watch), household maintenance assistance activities ((a flat rate of three hours per week)[9], incontinence equipment, modification of accommodation, training for technical aids and the training of the informal carer (a flat rate of six hours per year).

As indicated above, care provided outside the home of the beneficiary in institutions, can be provided in Semi-stationary centres[10] (*centres semi-stationnaires* – CSSTA), in Continuous care facilities accommodating dependent people day and night and providing them all the assistance and care required for their degree of dependency (établissements d'aides et de soins à séjour *continu* – ESC) or in Support and care establishments for intermittent stays[11] (établissements d'aides et de soins à séjour intermittent - ESI). The first one is part of the home care sector; the latter two belong to the residential care sector. But in the sense of "care residencies" as under scrutiny in this report, we count only the ESC. In 2018, 32.5% of the beneficiaries stayed in ESC. The number of LTC beds in 2017 was 8.28 per 100 population aged 65 and over[12].

The Luxembourg LTC system faces a range of challenges which stem already from before the pandemic and which have to be addressed in the future:

- A future constraint to access may come from the growing number of beneficiaries and hence the increased expenses for the LTC system (European Commission & Economic Policy Committee, 2018);
- This growing number of beneficiaries will also need more staff. At present, it is difficult to imagine, where these workers might come from;
- A group of contributors largely excluded from LTC benefits is the commuters: only a limited amount of social spending for LTC goes to cross-border and other mobile workers, in spite of their high percentage of the Luxembourg workforce (IGSS, 2020b);
- Another possible challenge with regards to the workforce is the potential decline in the number of persons willing to become informal carers; and
- Language is another challenge with regards to the workforce. Many commuters, predominantly from Belgium and France, are employed

9
The guarding activities and the household maintenance assistance activities belong to social care.

10
These could either be day care or night care centres; there are currently no night care centres in Luxembourg.

11
Equally accommodating dependent people day and night and providing them with all the assistance and care required according to their degree of dependency, but allowing an alternation between the stay in the centre and the stay in a private home. These category responds predominantly but not exclusively to the needs of people with disabilities.

12
See OECD (2019).

◂ back to table of contents

in the Luxembourg LTC sector[13], but a large portion of these do not speak Luxembourgish, which causes a comprehension problem with older Luxembourg beneficiaries who often are not fluent in French.

On 11 February 2020 the Minister for Family and Integration tabled a draft law in parliament aimed at amending the 1998 law called "ASFT" in order to improve the quality in institutions for the elderly. The ASFT law (Grand-Duché de Luxembourg, 1998b) regulated the relations between the State and the organisations working in social, family and therapeutic fields. The draft law, which is currently pending in the legislative process (Chambre des Députés, 2020a), concerns the complete renewal of the section dedicated to services for the elderly in order to clarify the definition of the different kinds of services for the elderly, to guarantee the quality of the services, as well as their flexibility and transparency.

2. DESCRIPTION OF THE EVOLUTION OF THE PANDEMIC IN SOCIETY AT LARGE, AND IN THE RESIDENTIAL CARE AND HEALTHCARE SECTORS MORE SPECIFICALLY

2.1. General description of epidemic: detection, scope and some data

On 22 January 2020 the Luxembourg government started to evaluate the situation in China and on 29 January 2020 an interministerial working group was installed. The first two persons showing symptoms were tested on 24 February 2020 and the first infected person was tested positive on 29 February 2020[14].

The first two dead were noticed on 17 March 2020.

The impact until 31 May 2020: 4,019 tested COVID positive out of 78,265 people tested; 110 dead out of which 59 were residing in residential care homes. The number of dead reached the maximum of 110 on 26 May 2020, from which 62 were men and 48 were women. On 31 May 2020 were counted 29 hospitalisations, out of which 3 were on intensive care. The maximum was reached on 4 April 2020 with 190 hospitalisations and the maximum of intensive care patients with 35 was reached on 3 April 2020 and again on 15 April 2020.

On 31 May 2020, Luxembourg was among 9 European countries showing a cumulative incidence of ≥400 cases per 100,000 population[15].

The number of 110 dead reached at 26 May 2020 (and which stayed unchanged till 10 July 2020), corresponds to 18.1 reported dead per 100,000 population, which was more than the ratio for Germany (10.8) and Austria (7.9), but much less than for the other neighbouring countries France (44.5) and Belgium (85.2), and also less than the Netherlands (35.4). But with regards to the infected, the reported cases per 100,000 population is by far the highest for Luxembourg (698.0) against 233.6 for Germany, 199.2 for Austria, 243.2 for France, 537.2 for Belgium and 291.0 for the

13
About 60 % of all health professionals working in Luxembourg are foreign nationals: OECD / European Observatory on Health Systems and Policies (2019).

14
These and the following information can be found on the government website: https://coronavirus.gouvernement.lu/fr.html and other sites registered there, as for example for the figures that stem from https://data.public.lu/fr/datasets/donnees-covid19/, downloaded on 29 June 2020. Because of the narrow territory there exist now breakdowns of the numbers by region, age or social groups etc. Also, the first breakdowns on a regional basis were only published by end of July 2020.

15
This information stems from the World Health Organization: https://www.euro.who.int/__data/assets/pdf_file/0006/445920/Week-22-COVID-19-surveillancer-eport-eng.pdf.

back to table of contents

Netherlands.[16] This may depend on the fact that Luxembourg has tested from the beginning much more than other countries. Data from 26 April 2020 inform that whereas the mean number of people tested per 1,000 population was 27.7 for the OECD, it was 11.1 for France, 13.2 for the Netherlands, 30.0 for Belgium, 30.4 for Germany and 30.5 for Austria, and it was 75.8 for Luxembourg (being second after Iceland with 147.6 and before Lithuania as third with 52.0)[17]. This advance in the number of tests increased especially since the beginning of the large scale testing campaign.

On 27 May 2020 started a campaign of large scale testing[18], having a testing capacity of 20,000 tests per day, aiming at testing the whole population within 6 weeks. The project was set up to last until the end of July. By the end of June, some 170,000 people were tested, 4,245 from them were tested COVID positive.

On 29 May started a test activity at the Luxembourg airport[19]: every person could ask for a test after arrival.

The policy response

Luxembourg, similarly to most European countries, decided on an almost total lockdown in response to the COVID-19 pandemic, leading to an economic downturn as well as heavy social consequences. The different measures are described in the following.[20]

On 12 March the Government, through a ministerial decree (Grand-Duché de Luxembourg, 2020a, dated on 16 March 2020 and relying on an old law from 1885 regarding measures to ward off contagious diseases: Grand-Duché de Luxembourg, 1885), took a range of decisions including the closure of restaurants, cafes and other consumer lounges (exceptions: take-away and delivery services), all schooling and university education was switched to distance learning, child-care facilities were closed, as were most shops, except for those selling groceries, hygiene articles, newspapers and magazines, and some other essential items. Maintenance and repair work to accommodations was prohibited. “Social distancing” was established as a new motto, under the slogan “Bleift Doheem!” (Stay at home!).

On 18 March the Grand-Duke signed the regulation (“*règlement grand-ducal*”: Grand-Duché de Luxembourg, 2020b) declaring a state of emergency during ten days according to art.32.4 of the Constitution, which gives the government the power to rule through regulations and to amend existing laws without consulting Parliament. First rules concerning the limitation of travel for the public, the limitation of economic activities and modifying certain legal provisions were fixed in that same regulation, which was then amended several times in the following weeks. Other regulations and draft laws were to come after that.

Rapidly the government then made the eligibility conditions and other requirements for work at reduced hours (or partial unemployment; in French

16
All these figures stem from https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea, downloaded on 29 June 2020.

17
See: https://msan.gouvernement.lu/dam-assets/covid-19/brochures/la-strategie-de-test.pdf, downloaded on 29 June 2020.

18
See https://researchluxembourg.lu/covid-19-taskforce/testing-strategy/, downloaded on 29 June 2020.

19
See https://coronavirus.gouvernement.lu/fr/communications-officielles.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Bcommuniques%2B2020%2B05-mai%2B29-bausch-luxairport.html.

20
For the following information, see Urbé (2020).

◂ back to table of contents

"*chômage partiel*", in German "*Kurzarbeit*") more flexible. Affected workers get 80% of their gross wages capped at 250% of the minimum wage per month and with the minimum wage as floor.

As of 20 March construction sites had to close. A nearly total lockdown of the country started for one month.

On 21 March the Parliament voted a law (Grand-Duché de Luxembourg, 2020c) to extend the emergency state to 3 months.

On 25 March the government decided on a vast programme worth €8.8 billion (= 14% of Gross Domestic Product, GDP) to stabilise the economy. This included disbursements of €1.75 billion (€500 million for work at reduced hours for 2 months, €300 million for direct aid to businesses, €200 million for family leave – "*congé pour raisons familiales*" - , €50 million for "certified emergency compensation" for small businesses of up to 9 employees, i.e. €5,000 per case), €2.5 billion bank guarantees (representing 85%, the banks having to bear the remaining 15%) and €4.55 billion extended payment periods, of which € 1.55 billion is for taxes and €3 billion is for social security contributions for companies. To guarantee the financing of this programme, the Government was authorised to issue a state debt up to €3 billion. Public debt will still remain below 30% of GDP thereafter.

As an example of the depth of the economic downturn, on 18 April approximately 212,000 workers (out of a total employed workforce of 446,139 in March 2020) in more than 11,000 companies were on work at reduced hours and €440,000 million have been spent therefore so far.

On 15 April the Government announced the first stages of a limited return to work, whilst not yet having a comprehensive longer-term exit strategy. Construction sites, hardware stores, and garden centres opened again on 20 April, whilst wearing a mask became compulsory on public transport and everywhere where a distance of two meters between persons could not be guaranteed. A return to school was announced recommencing in stages, beginning on 4 May with the final-year classes, other secondary school classes progressively from 11 May and primary schools only from 25 May. Further gradual stages were decided after an initial observation phase of three weeks.

On 18 April the Prime Minister announced in Parliament that further measures would follow in the coming days and weeks to alleviate the consequences of the economic downturn, including a further €80 million for "certified emergency compensation" for small businesses up to nine employees (€5,000 per case) and between ten and twenty employees (€12,500 per case).

Further de-confinement stages were decided on a two-week basis, leading to a new increase of the number of infected. The low point was reached on 26 June with only 8 hospitalisations, 1 person on intensive care,

◂ back to table of contents

respectively on 14 June with only 2 new infections. On 30 July 2020 were count3ed again 48 hospitalisations, 7 persons on intensive care, meanwhile 114 dead and a number of 78 new daily infections.

On 24 June 2020 the emergency state voted by Parliament came to an end. A number of regulations that had been taken in the meantime were prolonged through a range of new laws voted in Parliament on 22 June 2020 (namely Grand-Duché de Luxembourg, 2020d and 2020e) and further amended and updated thereafter.

2.2. The effects of the epidemic on the healthcare system[21]

At a very early stage, the development of the crisis led to a total reorganisation of the health sector[22].

Doctors' offices and practicing health professions were closed, only teleconsultations were allowed.[23] Dentists' offices were closed too, only three especially equipped cabinets remained for the treatment of urgent cases. All these offices reopened only after 29 April 2020, under strict limitations and conditions.[24] Doctors and other health professions in liberal exercise and partly without job through these measures were offered a fixed-term contract with the government, the president of the Association of Doctors and Dentists ("*Association des médecins et médecins-dentistes*" – AMMD) was appointed to be the national coordinator of the doctors, named the national medical coordination.

Hospitals started to implement two different systems (from reception to diagnostic stages through to treatment and floor care and intensive care) for "normal" and corona patients. At the same time all the surgical operations, and more generally all the non-urgent treatments, were stopped, the appointments already organised were cancelled (normal activities were resumed again from 4 May 2020[25]). Some of the normal care beds were turned into supplementary beds of intensive care to increase capacities. Supplementary respirators were ordered and an additional capacity of around 100 care beds was provided by the rent of a NATO tent that was flown in from Bari (Italy) in 6 flights by Luxembourg's national cargo airline Cargolux, one of the largest scheduled all-cargo airlines in Europe, which also flew in protection masks and other protection material from China, as one of the stakeholders of it is Henan Civil Aviation Development and Investment from the Chinese province of Henan.

Outside the hospital sector, health care was organised alongside three lines of care or guard lines:

- Guard line N ° 1: medical care in Advanced Care Centres (CSA) and increased use of home visits in COVID patients;
- Guard line N ° 2: medical care by teleconsultation and home visits in non-COVID patients; and
- Guard line N ° 3: Medical care for aid and care establishments (including care residencies for the elderly) and visits to aid and care

21
Before the pandemic, the Luxembourg health system can be characterised in 2017 by the following indicators: 3 doctors per 1,000 population, 43% of the, being older than 55 years; 11.7 practising nurses per 1,000 population; 4.7 beds per 1,000 population, see OECD (2019).

22
See https://gouvernement.lu/dam-assets/documents/actualites/2020/04-avril/Organisation-systeme-de-sante-covid.pdf.

23
See https://msan.gouvernement.lu/fr/actualites.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Bcommuniques%2B2020%2B04-avril%2B09-plateforme-teleconsultation.html.

24
See https://sante.public.lu/fr/espace-professionnel/recommandations/direction-sante/000-covid-19/000-covid-191-annexes/ordonnance-reprise-activite-medicale.pdf.

25
See https://coronavirus.gouvernement.lu/fr/communications-officielles.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Barticles%2B2020%2B04-avril%2B29-briefing-lenert-ammd.html.

back to table of contents

establishments for COVID and non-COVID patients (more about this guard line, see sub-section 3.2).

Three regional medical houses accommodating doctors on duty *("maisons médicales de garde")*[26] have to address the emergencies outside the opening hours of medical practices, to relieve the emergency services of hospitals. In a first stage, these were now exclusively reserved to patients with symptoms of COVID-19. Then they were totally closed until 25 May 2020, while four newly implemented regional "advanced care centres" ("*centres de soins avancés*" – CSA)[27] took over, starting between 22 and 25 March 2020. These new structures were designed to operate by two strictly separate consultation channels - the first was designed to accommodate patients showing signs of infection with the Covid-19 virus, the second allowed for patients who came to the centre. with no sign of infection from the Covid-19 virus. To limit waiting times as much as possible, each consultation channel provided for the care of several patients at the same time. The intention was, that these centres should be the entry point for anybody to the health system, patients being dispatched from there for subsequent treatments. Therefore, these CSA had also two different lines each, one for "normal" and one for corona patients. The staff for these CSA was recruited from the ones formerly present in the "*Maisons médicales*", from other professionals (see above about the doctors and professionals in liberal exercise), but also pensioners were reactivated and volunteers such as medical students were recruited. The CSA functioned until 8 June 2020. They were put on standby, with the possibility of reopening them when the time came.

In the same sense a national health reserve ("*réserve sanitaire nationale*") was created[28].

The "*Centres de soins avancés*" closed on 29 May (Ettelbruck and Grevenmacher) and 8 June (Luxexpo and Rockhal) respectively, and from 25 May on the "*Maisons médicales*" took over again. In these CSA, a total of, 17,592 tests were performed, of which 7,739 were positive. 9,108 different people were tested and 181 people were referred to the hospital emergency rooms.

"Research Luxembourg" is a joint initiative of the main players in Luxembourg's public research [Luxembourg Institute of Health (LIH); Luxembourg Institute of Socio-Economic Research (LISER); Luxembourg Institute of Science and Technology (LIST); National Health Laboratory (LNS); University of Luxembourg; National Research Fund (FNR)], under the coordination of the Ministry of Higher Education and Research. They joined their forces and possibilities in order to mobilise its knowledge and its human and material capacities.[29] A "Task Force for the Coordination of the Public Research Sector in the Context of the COVID-19 pandemic" has been created to provide the healthcare system with all of the combined expertise available to the Luxembourg public research sector. This Task Force elaborated also the "large scale testing" strategy (see sub-section 2.1).

26
These are general practitioner offices covering out-of-hour care on evenings and week-ends.

27
For more details see https://statistiques.public.lu/catalogue-publications/Flash-COVID/2020/01-2020.pdf.

28
See https://msan.gouvernement.lu/fr/actualites.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Bcommuniques%2B2020%2B04-avril%2B03-reserve-sanitaire-nationale.html.

29
See https://researchluxembourg.lu/publications/.

back to table of contents

2.3. The epidemic in the public and political debate

There has been no opinion surveys conducted on the COVID-19 sanitary crisis and the measures taken by the government. However, a periodically conducted survey about the popularity of the politicians, organised by the largest daily newspaper and the largest radio and television station, and published on 9/10 June 2020 showed that in addition to the prime minister, especially the health minister, who has only been in office since February, has gained considerable approval[30]. This can lead to the assumption that, according to the majority of the population, they have done a good job.

At the beginning there was a great deal of agreement between government and opposition, the vote in the parliament to extend the state of emergency by three months was even unanimous. In view of the threat and the lack of knowledge about the virus, the population also agreed to the measures and the lockdown. But the critical voices increased with the length of the lockdown. Especially economic actors have expressed their impatience to be able to reopen as soon as possible.

With the first easing of the state of emergency, and even more so in the coming weeks with more and more easing, this general agreement between all parties was lost. The opposition criticised the government for the easing measures taken and proposed others, and furthermore it complained of a lack of transparency and that it could not access all the information.[31]

Also the media at a certain moment complained of a lack of transparency and that they could not access all the information. As an example, the information which special units, task forces and working groups were established, and who were the members of these units was not published at the beginning, under the pretext of data protection. After the parliamentary opposition and the media had demanded a publication for weeks, this was finally carried out on 28 April 2020[32].

As nearly all the stakeholders in the beginning, the trade-unions also remained silent and supported the government's emergency measures[33]. But soon they started to ask to be involved in policy development in response to the pandemic, as during the first phase of the COVID-19 sanitary crisis, social partners were not contacted. When trade-unions called on the Prime Minister to convene a tripartite summit[34], he refused this for weeks. With the first de-confinement measures, the government set up an ad-hoc advisory group consisting of eight personalities, among whom two representatives of the employers and the president of the Workers Chamber ("*Chambre des salariés*"). But none of them had been designated by the social partners, they were chosen by the government. A first round of separate meetings between the government and the two sides of the social partners took place on 14 May 2020 "to take stock of the economic and societal impact of the crisis"[35]. The unions continued to call for a formal tripartite meeting. The Prime Minister agreed to convene again two separate meetings on 10 June 2020. There the government "listened to feedback from our social partners, in particular on the most recent measures

30
See https://www.rtl.lu/news/national/a/1546659.html or https://www.wort.lu/de/politik/politmonitor-das-feld-von-hinten-aufgerollt-5f06e919da2cc1784e361339.

31
See https://www.rtl.lu/news/national/a/1549500.html or https://www.wort.lu/de/politik/opposition-veraergert-wir-haben-es-satt-5f0eec1eda2cc1784e361a42.

32
See https://coronavirus.gouvernement.lu/fr/communications-officielles.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Bcommuniques%2B2020%2B04-avril%2B28-inventaire-groupes-travail.html.

33 One has to bear in mind that Luxembourg belongs to the so-called Bismarck countries, which means that social partners are involved in the management of social security (here especially the health insurance and the dependency insurance, organised by the CNS – see subsection 1.1); they are also involved in the political steering of socio-economic developments through the installation of tripartite negotiations. For more details see e.g. Urbé (2012 and 2013).

34
In the so-called "tripartite" dialogue, the main social and economic policy directions are discussed aiming at a consensus or at least a compromise (Nati-Stoffel, 2015, p. 2).

35
See https://gouvernement.lu/fr/actualites/toutes_actualites/communiques/2020/06-juin/10-echange-gouvernement-partenaires-sociaux.html.

◂ back to table of contents

provided for in the recovery plan". Afterwards the government announced a formal tripartite meeting scheduled to take place in the first half of July. Just before the bipartite meetings the Minister of Labour, Employment and the Social and Solidarity Economy had reached an agreement with the social partners on the future conditions of work at reduced hours. In the tripartite meeting a range of measures aimed at combatting unemployment were proposed and they were cast into law over the next few weeks. However, at that moment it was already clear that these measures would not be sufficient and therefore a new tripartite meeting should take place after the summer holidays.

The unions working in the school sector also disagreed with many measures during the de-confinement and complained that they had not been consulted.

In the public opinion, also reported by the press, there was at the beginning a large feeling of solidarity and a conviction that the government's measures were the right ones. But again, with the increasing easing measures, broad parts of the population behaved as if the pandemic was over and they could lead a life like before: the barrier gestures were neglected and as a result the numbers of infected and dead people rose again.

At the same time, the de-confinement stages were accompanied by statements about the endangerment of freedom, not only by corona sceptics and conspiracy theorists, as in other countries, but even by the Human Rights Commission, the National Ethics Council and the State Council. This High Corporation even prevented the Covid-law of 24 June 2020 from introducing stricter regulations for private celebrations (Chambre des députés, 2020b), an attitude that it then had to revise in view of the increasing numbers of infections. The law was then tightened 14 days later.

"RECOVid" is a group of economists based in Luxembourg who assist the "Task Force for the Coordination of the Public Research Sector in the Context of the COVID-19 pandemic" (see sub-section 2.2). With a working note (Work Package 7) it aims to provide knowledge on the economic issues related to the COVID-19 crisis[36].

The working note provides a summary of ongoing research as well as estimations of the direct economic impact of the health crisis and resulting policy measures. We reproduce in the following some of their main messages:

- Assuming a baseline-as-usual trend, back-of-the-envelope calculations suggest that the current lockdown could reduce Luxembourg's monthly output by 28 to 42% depending on the deterioration of the international economy and budget support policy.
- Though, many workers in lockdown industries (e.g. wholesale and retail trade, or accommodation and food service activities) can incur income losses. Fiscal measures are needed to compensate for their losses. In addition, the effect on well-being goes well beyond the monetary impact of the crisis. Welfare losses might be more det-

36
See https://www.liser.lu/documents/RECOVID/RECOVid_working-note_full-1.pdf.

back to table of contents

rimental for health professionals and for minority groups such as single-person households and households without access to internet.

- Maintaining a satisfactory state of hibernation that allows the economy to recover quickly would require a deficit equal to the loss of activity due to the lockdown. Assuming a two-month confinement, this means that Luxembourg's government could inject 3.9 to 5.9% of its baseline-as-usual GDP in the economy. While Luxembourg can probably afford this effort, many countries (including European member states) will not be able to cope alone and will need fiscal support.
- Given the previous finding, the risk of a systemic collapse of the financial system both globally and at the European level cannot be excluded.
- From a longer term perspective, the COVID-19 crisis might lead to permanent effects. In addition to slowing down capital accumulation, it might induce long-term changes in deep preference parameters and in political preferences, affect international linkages and cooperation, lead to a collapse of the neo-liberal model of globalization, and require increasing development assistance.

Foundation Idea, a Luxembourg think tank has published different articles on the consequences of the crisis, exit strategies and recovery scenarios, as well as results of a survey done with a panel of more than 100 economic and political deciders, 49 of them having participated[37].

It is expected by experts, that the Luxembourg economy will drop in 2020 by 3 to 6% of GDP[38]. Some economists are expecting a V-shaped recovery in late 2020 and early 2021, but it is still too early for such predictions, since no-one currently knows how long precautionary measures will have to last, or whether the current easing will lead to a new exponential spread of the virus.

There is a certainty among a lot of stakeholders, that the exit strategies from the crisis, and all the recovery policies after the crisis must under no circumstances be used again as a pretext for reducing the problems of public finances at the expense of the most vulnerable, as was the case during the crisis of 2008/2010, or rather 2008-2014 with the famous "*Zukunftspak*" of 2014 (=future package: Grand-Duché de Luxembourg, 2014).

3. DESCRIPTION AND ANALYSIS OF THE MEASURES ADOPTED TO ADDRESS THE IMPACT OF THE PANDEMIC ON THE RESIDENTIAL CARE SECTOR FOR THE OLDER-AGE POPULATION IN LUXEMBOURG

3.1. Background of preparedness for the Crisis

Luxembourg was not really prepared for such a pandemic. The only legal provisions were a law from 1885 (!) concerning "the measures to be taken to prevent the invasion and spread of contagious diseases". It was on the basis of this ancient law that the first measures were taken: the ministerial decree ("*Arrêté ministériel*") on "various measures relating to the fight

37
See https://www.fondation-idea.lu/.

38
See e.g. https://statistiques.public.lu/catalogue-publications/conjoncture-flash/2020/PDF-Flash-06-2020.pdf.

◂ back to table of contents

against the spread of the covid-19 virus" (Grand-Duché de Luxembourg, 2020a).

Another law was the one from 1980 on the Health Directorate ("direction de la santé": Grand-Duché de Luxembourg, 1980). This law defines the missions of the Health Directorate, including in particular public health, and more particularly to ensure compliance with the legal and regulatory provisions in the field of public health, to ensure the control of the health situation of the country and to take the emergency measures necessary to protect health. To this end, the doctors of the health department have the capacity of judicial police officers in public health matters and when it comes to preventing or fighting contagious diseases or contaminations, they have the right to themselves issue binding prescriptions.

The last time a pandemic plan had to be rolled out was the fight against influenza A (H1N1) in 2009/10. It was a simple plan of information, screening, detection and monitoring, coupled with a vaccination campaign[39]. So nothing specific that could have guided those responsible in the present crisis.

To further characterise Luxembourg's degree of non-preparation, we look at the material and logistical conditions. As the Health Minister admitted in an interview, there was not only insufficient protective material at disposal in the beginning, but the Ministry had no information about existing (or non-existing) stocks, just as little as about free intensive care beds and other capacities.[40]

Other actors named as threats the absence of sufficient intensive care beds, masks and other medical material, as well as the lack of staff and the dependency on foreign staff that might not be available due to border closures or requisitioning in the home country (Luxembourg's health sector recruits about 45%[41] of their workforce from outside the country, mostly commuters from France, Belgium and Germany)[42].

As the instruments described above were not appropriated to manage the situation, the government relied on paragraph 4 of article 32 of the Constitution, which since 2017 foresees the possibility to declare the state of emergency (Grand-Duché de Luxembourg, 2017b); this was originally intended to be able to react in the event of a terrorist attack[43]. This state of emergency gives the government the power to rule through regulations and to amend existing laws without consulting Parliament.

One can moreover doubt the constitutionality of the declaration of the state of emergency, because the text of Art.32.4 of the constitution provides as one of the conditions that "… after noting the urgency resulting from the impossibility of the Parliament to legislate within the appropriate deadlines …"[44], which obviously was not the case: the parliament extended the state of crisis for three months by passing a related law only three days later, and parliament sat for a total of 21 sittings during the period of the state of crisis, and during this time, many laws were passed in record time[45].

39
See e.g. https://sante.public.lu/fr/actualites/2009/06/OMS-phase6/index.html.

40
See https://msan.gouvernement.lu/fr/actualites.gouvernement%2Bde%2Bactualites%2Btoutes_actualites%2Binterviews%2B2020%2B04-avril%2B10-lenert-luxemburgerwort.html.

41
OECD/European Observatory on Health Systems and Policies (2019).

42
See https://www.reporter.lu/luxemburg-gesundheitssystem-coronavirus-warum-luxemburgs-krankenhaeusern-der-kollaps-droht/.

43
The text of article 32.4 reads literally as follows: "In the event of an international crisis, real threats to the vital interests of all or part of the population or imminent danger resulting from serious attacks on public security …" (translation by the author, original text: "En cas de crise internationale, de menaces réelles pour les intérêts vitaux de tout ou partie de la population ou de péril imminent résultant d'atteintes graves à la sécurité publique …").

44
Translation by the author, the original text reads: "… après avoir constaté l'urgence résultant de l'impossibilité de la Chambre des Députés de légiférer dans les délais appropriés …".

45
See https://chd.lu/wps/portal/public/Accueil/TravailALaChambre/Seances-Publiques/CalendrierSeances/!ut/p/z1/lZHLDoIwEEW_xQ8wHYYqZ-VnQVEQxaBDoxtRHTBNeMejCrx-eMC3GBOruZ3Dl3HkSShMhC-3fRZ1bosVNbkqRzvJjjZrj2KIKyQA-s6ncyvaBCajFomfAugEB2eNjgkgVk-jk__3vpN_6ewSyHx8T2bVgro3giXD-hu8YIBOKnoGsh7PFL0HeDb1Okz-RbWzp-5roEUAuaHBvAGbji-aQKjZN-MydF5l-qDrZXk8ZSStL9dTW1aH9l-kNo8qjKAHtDdX-zvlg8ACNq0yb/p0/IZ7_KHCC1240N8KQ10AN3G-1BK33084=CZ6_D2DVRI420G7Q-402JEJ7USN3847=LA0=H-F=Ecb!1596894896251=javax.portlet.action!nextTrimester==/#Z7_KHCC1240N8KQ10AN3G1BK33084.

back to table of contents

The Ministry of Health organised a range of special units, task forces and working groups[46], to analyse, prepare, organise, monitor and evaluate the evolution of the pandemic, the public response and the effects on the population and the health sector especially. These units were formed from the employees of the Health Directorate, the Ministry of Health and other ministries. The High Commissioner for National Protection also participated (even in a leading position[47]), as did the army, several secondments from globally operating companies, external consultants and volunteers (pensioners, students).

One of the Task Forces that advised the Ministry of Health was the "Task Force for the Coordination of the Public Research Sector in the Context of the COVID-19 pandemic" (for more see sub-section 2.2 and 2.3).

The actions and measures taken by the government were all intended to prevent the infection of large sections of the population, on the one hand to protect the population, especially the elderly, but on the other hand, above all, to prevent overloading of the hospitals and especially the intensive care units.

So, on 12 March the Government, through the ministerial decree named above took a range of decisions leading to a more or less total lockdown (see sub-section 2.1).

A range of regulations and laws followed to contain the pandemic and alleviate its consequences. There were plans to replace the ruling state of emergency by a new pandemic law replacing the one from 1885, but it turned out that this would have taken too long. So the government opted for a range of new specific "COVID-laws". The plan for a new pandemic law will be followed up later, once the current crisis being over.

3.2. General Impact of the Epidemic on the Residential Care Sector and Policy Responses

In general, it must be pointed out at this point that in Luxembourg, a small country with a little more than 600,000 inhabitants and just 52 residences for older people, there are no multiple structures. There are no regional authorities, apart from the national ones only the municipal ones and the latter had no role to play in the questions under scrutiny in this report. Therefore, the presentation of the impact as well as the responses and the coordination is much easier than would be the case in a larger country.

At the beginning of the crisis the whole attention addressed hospitals. When it came to protective clothing (masks, vests, overalls, ...), there was initially too little available[48]. As there was not enough material to supply the hospitals, there were insufficient supplies to other actors like resident doctors, pharmacies and also care residencies for the elderly (and disabled people too)[49]. These actors, but even hospitals too, tried to get additional protection material through private donations and volunteers who privately tailored masks, or through other channels.[50]

46
See https://coronavirus.gouvernement.lu/fr/communications-officielles.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Bcommuniques%2B2020%2B04-avril%2B28-inventaire-groupes-travail.html.

47
See https://gouvernement.lu/dam-assets/documents/actualites/2020/04-avril/28-inventaire-groupes-travail/MS-CC-COVID19-organigramme-Cellule-de-crise.pdf.

48
See https://msan.gouvernement.lu/fr/actualites.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Binterviews%2B2020%2B06-juin%2B30-gaulier-lessentiel.html.

49
See e.g. the results of a survey of institutions of palliative medicine: Association Luxembourgeoise de Médecine Palliative (2020).

50
See e.g. https://www.tageblatt.lu/headlines/xavier-bettel-und-paulette-lenert-zu-besuch-im-krankenhaus-auf-kirchberg/.

◂ back to table of contents

Even on 6 April 2020 a recommendation from the Health Directorate on the handling of protective materials, in particular masks, gave still advice to the medical and paramedical staff to handle the masks carefully and to minimize consumption (e.g. reduce the number of masks used, limit the use of masks by patients, etc.), which shows that the regular supply was not yet assured.

From the very beginning (13 March 2020) access to the care residencies for elderly (and disabled) was restricted to professional personnel. No visitors, nor suppliers were accepted.

After the first infections had been discovered in some residencies, only on 30 March 2020, the Health Director ("*Directeur de la santé"*), through a prescription, ordered that nursing staff should no longer be allowed into the residencies if they had signs of infection[51].

And only around two weeks later a general testing campaign was launched: in response to a health situation deemed critical in institutions for the elderly, between mid-April and early June, tests were systematically offered to all residents and staff. These tests made it possible to stabilize the situation in this sensitive sector. As of 4 May 2020 tests were carried out in 49 out of 52 residencies. 5,017 out of a total of 5,780 residents (=91.8%) were tested, out of these 10 test (=0.2%) were positive. 6,408 out of a total of 7,924 staff members were tested, from which 12 (=0.2%) showed a positive test. [52] Testing in residential care did not continue periodically. Only when in autumn numbers of COVID-19 cases (and accordingly also deaths) began to increase significantly, a new wave of testing was deployed by the Ministry of Health.

Starting on 29 April 2020, visits were again possible, but under restrictions and conditions, only in especially equipped rooms designated by the respective residence and only by prior reservation. Recommendations how to handle the crisis in care residencies were edited by the Health Directorate as well as by the Ministry for Families, Integration and the Greater Region more or less on a two-week basis[53]. One of the recommendations was to put residents in quarantine for two weeks in the event they returned from a necessary outing, e.g. for a medical examination; some residents who were forced to go regularly to the hospital for dialyse treatment saw themselves almost permanently placed in quarantine.

This practice, which was heavily criticized by those affected and their families and even led to a parliamentary debate, was stopped after a new recommendation issued by the Ministry for Families, Integration and the Greater Region, drafted with the approval of the Health Directorate[54].

From 1 June 2020 on visits outside (in the park, at the terrace, ...) were again allowed, and from 2 July 2020 on again in the room of the resident.

The initial phase of around 6 weeks where no visits were possible and also the following weeks with their restricted possibilities led for a lot of residents to extremely heavy situations of distress, especially in the case of

51
See https://sante.public.lu/fr/espace-professionnel/recommandations/direction-sante/000-covid-19/000-covid-191-annexes/ordonnance-reseaux-soins-domicile-structures.pdf.

52
See https://chd.lu/wps/PA_RoleDesAffaires/FTSByteServingServletImpl?path=682BFE29A17F0CE5BB8DA942A1BC4663AE7C6CFF9722FFD9B499226EB9A3A64378DDB2EE38B06F94E857E8477BCBBC45$B6A19C0CB81FA22F66963C9CB5BB6B81.

53
See https://sante.public.lu/fr/espace-professionnel/recommandations/direction-sante/000-covid-19/index.html.

54
See https://sante.public.lu/fr/espace-professionnel/recommandations/direction-sante/000-covid-19/000-covid-191-annexes/recommandations-CIPA.pdf.

back to table of contents

illness or dying. It was also a heavy burden for families not to be able to support their relatives in the event of illness or death[55]. A lot of letters to the editor in the daily newspapers testify to this.

With the total re-organisation of the health system (see sub-section 2.2) a special guard line N° 3 was installed as part of the organisation of the health system during the COVID-19 pandemic to ensure medical care within the care residencies for elderly themselves[56]. Thanks to this on-call line, each establishment had an on-call doctor. Guard line 3 operated 7 days a week, 24 hours a day and covered both visits to establishments as well as teleconsultations. The availability of doctors 24 hours a day contributed to the reduction in the number of hospitalisations and visits to polyclinics and has contributed to the development of continuous and personalised medical care within aid and care establishments.

Following the very positive results of the establishment of the guard line 3 in aid and care establishments during the health crisis linked to COVID-19 and to the satisfaction of all stakeholders, the Governing Council, in a meeting on July 15, 2020, adopted the pilot project relating to the establishment of a service for the continuity of general medicine care in the evenings, at night, at weekends and on public holidays.[57]

The goals of this pilot project are to perpetuate the care system put in place during the health crisis linked to COVID-19, better coordination and medical organization to improve the quality of care as well as better continuity of care avoiding unnecessary hospitalizations in the various structures of the country.

This system will be applied from September 1, 2020 until August 31, 2022, therefore for a period of 2 years and provided by general practitioners. It will be organized by the Association of Doctors and Dentists (AMMD) with the collaboration and financial support of the State.

This guard line, as well as the reorganised healthcare system in general put in place, has also contributed to the low mortality rate in Luxembourg compared to neighbouring countries, especially in Belgium and France. Thus, according to the mortality monitoring study at European level, the excess mortality observed for Luxembourg during the acute phase of the crisis remains below the marked level of a substantial increase; it is also much lower than that observed in our neighbouring and European countries (BE, FR, EI, IT, NL, ES, CH, UK).

3.3. Case Analysis

Main elements that can be retained include:

- The poor preparedness of the health and care sector;
- On the other hand, the rapid reaction and the very clear decisions in the first stages; and
- The growing difficulties in organizing the easing phases.

55
See e.g. https://www.wort.lu/de/politik/wie-im-gefaengnis-senioren-fuehlen-sich-eingesperrt-5ee8f661da2cc1784e35fcc1.

56
Normally care residents, who are considered to be “at home” in their residence have the free choice to call in their personal doctor, the residence is not organising medical care.

57
See https://msan.gouvernement.lu/fr/actualites.gouvernement%2Bfr%2Bactualites%2Btoutes_actualites%2Bcommuniques%2B2020%2B07-juillet%2B15-continuite-soins-covid.html.

◂ back to table of contents

Therefore, the lessons learned include:

- Better preparedness of the health and care sector, stop to savings in the health sector;
- Elaboration of plans and response pathways in preparation of a next crisis;
- Assuring the material stocks necessary; and
- Stop to the reliance on China for essential items.

It should be provided for masks, blouses, respirators, drugs, vaccines in Europe instead of relying on China. During the crisis, first reactions have taken place: some companies converted to mask fabrication (textile), disinfectant production (paint manufacturers, but also distilleries etc.), some specialized and increased in valve production for respirators or protective clothing: this could continue, but subsidies will be probably necessary because of the wage gap between Europe and Asia!

For the future of the residential care sector, some challenges can be described.

As a lesson from the crisis we can retain that the preparedness of the sector for such situations has to be massively improved, preparedness in terms of organisation, staff, logistics etc. Protective equipment as well as staff training was only implemented after the first weeks of the pandemic, there was no preparedness in this sense. Therefore, it is clear for all the actors, that this situation should not occur once more and that preparedness has to be improved.

There is also one issue on quality (and reactivity in such a crisis situation): the management of the LTC system involves a range of actors (see section 1): the CNS is responsible for contracting providers and the disbursement of payments, the AEC's mission is to ascertain the state of dependency and to establish a care plan incorporating the help and care required by the dependent, to monitor the quality of services provided and their adequacy in meeting the needs of dependents and to inform and advise protected persons and bodies concerned with the prevention of addiction and the care of dependents. The IGSS provides control of social security institutions under the supervision of the Ministry for Social Security, which establishes the relevant laws for the sector. The Ministry of Health and the Ministry for Family, Integration and the Greater Region supervise the accredited providers. The providers themselves are responsible for the correct implementation of the care system, in combining human and material resources. COPAS is the representative organisation of care providers recognised as the collective bargaining party with the CNS (and the trade unions). For the moment, there are no real complaints on the complexity of the system and the multitude of actors, but future budget constraints may require a more rigorous management of the whole system.

A general issue is, how the sector can respond to the ever growing demand (European Commission & Economic Policy Committee, 2018): this

◂ back to table of contents

puts public finances under constraint and there is also an issue of finding enough qualified staff.

3.4. Examples of developments in specific care homes

Two interviews were conducted with two senior members in the management of care residencies.

Both have admitted that at the beginning they had no precise idea about the virus and they thought that just as in previous cases it would be limited to Asia. And when it became clearer that it would affect the whole world, they felt unprepared and uncertain about the measures to take. The seriousness of the situation in Italy on the one hand, and on the other the realisation that there was a lack of personal protective equipment and that there was no longer any way to obtain it were the starting points of increasing awareness.

Whereas one of them was contacted by the Ministry of Family, Integration and the Greater Region as well as by the Health Directory, the other one was not contacted during the first phases and he contacted himself the Coronavirus Helpline of the Health Directorate. In the following they were in contact with a lot of authorities, such as the Health Directorate, the Ministries for Health, Education, Labour, Social security and Family, as well as the National Health Fund and COPAS.

The residents were tested in the frame of the large scale testing (see sub-section 2.1) and in the cases of symptoms, as well as after periods of isolation. And exactly the same goes for the staff. The requirement of staff to test for COVID-19 was issued by the Health Directorate, the management of residencies or the responsible doctors. Staff and residents were trained to handle the situation in the first case by the team of hygienists of the health directorate and in the other by the heads of service, the heads of departments and the Directorate of the residence. Personal protective equipment was not provided in the first phase, then it was provided through the logistics unit of the crisis cell in the Health Ministry. The visits to residents by family members were not allowed at the beginning, limited afterwards according to the official recommendations (see sub-section 3.2). Measures were taken to isolate those who were infected from those who were not: a separate department for isolations was built in extremis to ensure the best possible separation between positive and healthy residents. In both cases the staff taking care of residents has been reinforced by the health reserve and by volunteers. Health care had to be adapted: in the event of infection, very intensified management was necessary along with increased monitoring of symptoms or warning signs; some treatments were not provided as a precaution, for example group physiotherapy activities.

In the beginning there were no real recommendations yet. Guidelines existed before, for the management of infectious diseases (Influenza, Norovirus etc.); these served as a basis for the establishment of more specific guidelines. More generally, the employees' knowledge of hospital hygiene

◂ back to table of contents

enabled them to define a concept which was quite close to the subsequent recommendations of the Health Directory. Above all, we therefore took measures to limit contagion and ensure the best possible functioning of our services. Our measures were subsequently revised in order to align them with the recommendations of the Health Directorate.

When an elderly person was infected with COVID-19, the person was automatically isolated. If there were several cases of infections and especially people who could not be isolated, for example people with dementia, the solution was “cohorting”: the infected people and the personnel who treated them were grouped together and scrupulously isolated from the other non-sick people.

There have been elderly people infected by COVID-19 who have not been hospitalised so as not to overload hospitals and to keep the elderly in their usual place of life and to guarantee them as much normalcy as possible, any hospitalisation not essential has been avoided. Hospitalisation is medically ordered and the decision is based on “end of life guidelines” expressed by residents and their families.

At the beginning, physical contact with infected people was generally prohibited. Contacts by phone, skype, facetime and others were facilitated and encouraged. Exceptions have been made in the event of end of life subject to very strict protection measures.

A third interview was conducted with a senior manager i.e. the head of the “elderly” division at the Ministry of Family, Integration and the Greater Region.

He admitted that at the beginning they had a lack of knowledge about the virus and how it spreads, about its contagiousness, etc.; their feelings were uncertainty and concern about news from neighbouring countries. He realised for the first time the severity of the pandemic on 13 March 2020, the same day they decided about the closure of residential care facilities and the ban on visits for the relatives of the residents. They had been contacted therefore by the Ministry of Health with which there has been a very close collaboration at all times of the situation, as well as with COPAS (*Confédération des Organismes Prestataires d’Aides et de Soins*), the representative association of service providers in the field of long-term care. This collaboration of the Ministry of Family with the Ministry of Health (and with Copas) is based on joint working groups, where fast and pragmatic solutions and support positions for residency managers have been developed, e.g. the recommendations that have been repeatedly adapted in the course of the sanitary situation, the line of care of the general practitioners in the residencies as well as the access to various medical substances for these doctors, … The Ministry of Family has also worked closely with the Sanitary Inspection (a Division of the Ministry of Health), on the one hand to provide the residencies with the necessary know-how, through training on the subject of hygiene and infection control, and by visiting the residencies individually together with the Ministry of Health and their specialists, to provide

◂ back to table of contents

them with information on how they might react in their situation and in their premises if frequent infections occur. The houses were individually advised and cared for when they expressed a need.

Recommendations for the whole long-term care sector were established by the Ministry of Family, Integration and the Greater Region and COPAS, these measures were each time advised by the Ministry of Health. These recommendations were about e.g. conduct of staff, protective clothing, introduce and monitor health measures, recognize symptoms and inform residents, organize family visits, etc.[58]

The measures taken included, as already mentioned above, the closure of residential care facilities, with on the one hand a ban on visits for the relatives of the residents, and on the other hand a ban on going out for residents. In the event that an outing was nevertheless necessary, e.g. for a medical examination, the resident saw himself quarantined for two weeks upon his return to the residence. This was extremely difficult for those residents who were forced to go regularly to the hospital for dialyse treatment: they saw themselves almost permanently placed in quarantine. Visits to residents by family members were forbidden since 13 March 2020, they were limited from 28 April 2020, and there was an open phase 1 from 30 May 2020 and a phase 2 from the end of the state of crisis (24 June 2020). To ensure compliance with hygiene rules during the visits, personal protective equipment was provided by the residencies both to residents and visitors.

The directors of the residencies were able at any time during the crisis to give exceptions from the restrictions regarding visits, in particular at the end of life of a resident. But in fact, some directors made little use of it, preferring to hide behind the ministerial order. Only on 20 May an order from the ministry provided more clarity.

Personal protective equipment for staff has been provided by health authorities as soon as it was available, which was not the case from the start because of supply problems and a lack of stored material, a lack of preparation and foresight.

58
See e.g. https://sante.public.lu/fr/espace-professionnel/recommandations/direction-sante/000-covid-19/index.html and https://mfamigr.gouvernement.lu/fr/dossiers/faq/faqnew.html.

◂ back to table of contents

Basic questionnaire for the directors of those residences

1. What do you remember about the early days when you heard about the epidemic? (We look for a general impression).

2. When did you become aware of the seriousness of the epidemic (we look for an initial reaction to see if that person took the initiative, or someone warned her/his about what was happening).

3. Which authorities contacted you? (depending on the role: 1) if the respondent is a manager of a residence, the answer could be: local, regional or national health and/or social services authorities, regional or national; no one; 2) if the respondent is a relative, the answer could be: the director of the residence; no one...).

4. In case the answer is "no one": Who did you contact for information on what to do?

5. What authorities have you been in contact with throughout the epidemic? For what purpose?

6. What were the main measures in your care home made to avoid Covid-19 contagion? (Could you describe these measures in detail? Timing: before there were cases in your care home, once the first case was detected, as the epidemic was already half way through, towards the end?). Examples:

   - Were the residents tested?
   - What were the central, regional local authorities, as well as the internal home care policies with regards to the requirement of staff to test for Covid 19?
   - Were staff and residents trained in any way to handle the situation?
   - Were personal protective equipments provided?
   - Were visits to residents by family members limited or restricted?
   - Were measures taken to isolate those who were infected from those who were not?
   - Was staff caring for the residents reinforced?
   - In particular, was healthcare reinforced in any way?
   - Other.

7. Why did you adopt these measures? (We look for any existing internal/external protocols? It is important to know if these protocols existed before the crisis or were elaborated afterwards).

8. What happened if an elderly person was infected by Covid 19? Did you have elderly people with Covid-19 that were not taken to hospital? If so, why.

9. Were any measures put in place so that relatives could somehow accompany the residents during the illness, or when it got worse?

10. Other concerns.

◂ back to table of contents

REFERENCES

Association Luxembourgeoise de Médecine Palliative (2020), *Pandémie et soins palliatifs - impact du covid19 sur la prise en charge des patients palliatifs au Luxembourg*, Luxembourg.

Chambre des Députés (2020), *Projet de loi portant sur la qualité des services pour personnes âgées et portant modification de : 1° la loi modifiée du 16 mai 1975 portant statut de la copropriété des immeubles bâtis ; 2° la loi modifiée du 8 septembre 1998 réglant les relations entre l'Etat et les organismes œuvrant dans les domaines social, familial et thérapeutique*, Document parlementaire N°7524, Luxembourg.

Chambre des Députés (2020b), *Projet de loi portant sur la qualité des services pour personnes âgées et portant modification de : 1° la loi modifiée du 16 mai 1975 portant statut de la copropriété des immeubles bâtis ; 2° la loi modifiée du 8 septembre 1998 réglant les relations entre l'Etat et les organismes œuvrant dans les domaines social, familial et* thérapeutique*, Avis de la chambre des Salariés,* Document parlementaire N°7524/01, Luxembourg.

Directorate-General for Economic and Financial Affairs (2019), *Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability*, European Economy No 105, June 2019, pp. 415-421. Available at https://ec.europa.eu/info/sites/info/files/economy-finance/ip105_en.pdf.

European Commission & Economic Policy Committee (2018), *The 2018 Ageing Report: Economic and budgetary projections for the 28 EU Member States (2016-2070)*. European Economy Institutional Paper, No. 079.

Grand-Duché de Luxembourg (1885), *Loi du 25 mars 1885 concernant les mesures à prendre pour parer à l'invasion et à la propagation des maladies contagieuses,* Journal officiel du Grand-Duché de Luxembourg, Mémorial A 20 du 4 avril 1885, Luxembourg.

Grand-Duché de Luxembourg (1980), *Loi du 21 novembre 1980 portant organisation de la direction de la santé,* Journal officiel du Grand-Duché de Luxembourg, Mémorial A 79 du 27 novembre 1980, Luxembourg.

Grand-Duché de Luxembourg (1998a), *Loi du 19 juin 1998 portant introduction d'une assurance dépendance,* Journal officiel du Grand-Duché de Luxembourg, Mémorial A 48 du 29 juin 1998, Luxembourg.

Grand-Duché de Luxembourg (1998b), *Loi du 8 septembre 1998 réglant les relations entre l'Etat et les organismes œuvrant dans les domaines social, familial et thérapeutique*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 82 du 24 septembre 1998, Luxembourg.

◂ back to table of contents

Grand-Duché de Luxembourg (2005), *Loi du 23 décembre 2005 modifiant 1. différentes dispositions du Code des assurances sociales en matière d'assurance dépendance 2. les articles 12, 92 et 97 du Code des assurances sociales 3. la loi du 25 juillet 2005 modifiant 1) le Code des assurances sociales; 2) la loi modifiée du 3 août 1998 instituant des régimes de pension spéciaux pour les fonctionnaires de l'Etat et des communes ainsi que pour les agents de la Société nationale des chemins de fer luxembourgeois; 3) la loi modifiée du 28 juillet 2000 ayant pour objet la coordination des régimes légaux de pension 4. la loi du 8 juin relative aux régimes complémentaires de pension*, Journal officiel du Grand-Duché de Luxembourg, Mémorial A 215 du 28 décembre 2005, Luxembourg.

Grand-Duché de Luxembourg (2014), *Loi du 19 décembre 2014 relative à la mise en œuvre du paquet d'avenir – première partie (2015)*, (référence abrégée), Journal officiel du Grand-Duché de Luxembourg, Mémorial A, No 257 du 24 décembre 2014, Luxembourg.

Grand-Duché de Luxembourg (2017a), *Loi du 29 août 2017 portant modification 1. du Code de la sécurité sociale; 2. de la loi modifiée du 15 décembre 1993 déterminant le cadre du personnel des administrations, des services et des juridictions de la sécurité sociale; 3. de la loi modifiée du 25 mars 2015 fixant le régime des traitements et les conditions et modalités d'avancement des fonctionnaires de l'État*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 778 du 1 septembre 2017, Luxembourg.

Grand-Duché de Luxembourg (2017b), *Loi du 13 octobre 2017 portant révision de l'article 32, paragraphe 4 de la Constitution*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 908 du 16 octobre 2017, Luxembourg.

Grand-Duché de Luxembourg (2018), *Loi du 10 août 2018 modifiant 1. le Code du travail; et 2. le Code de la sécurité sociale en matière de maintien du contrat de travail et de reprise progressive du travail en cas d'incapacité prolongée*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 703 du 21 août 2018, Luxembourg.

Grand-Duché de Luxembourg (2020a), *Arrêté ministériel du 16 mars 2020 portant sur diverses mesures relatives à la lutte contre la propagation du virus covid-19*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 149 du 16 mars 2020, Luxembourg.

Grand-Duché de Luxembourg (2020b), *Règlement grand-ducal du 18 mars 2020 portant introduction d'une série de mesures dans le cadre de la lutte contre le Covid-19*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 165 du 18 mars 2020, Luxembourg.

◂ back to table of contents

Grand-Duché de Luxembourg (2020c), *Loi du 24 mars 2020 portant prorogation de l'état de crise déclaré par le règlement grand-ducal du 18 mars 2020 portant introduction d'une série de mesures dans le cadre de la lutte contre le Covid-19*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 178 du 24 mars 2020, Luxembourg.

Grand-Duché de Luxembourg (2020d), *Loi du 24 juin 2020 portant introduction d'une série de mesures concernant les personnes physiques dans le cadre de la lutte contre la pandémie Covid-19 et modifiant la loi modifiée du 11 avril 1983 portant réglementation de la mise sur le marché et de la publicité des médicaments*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 524 du 24 juin 2020, Luxembourg.

Grand-Duché de Luxembourg (2020e), *Loi du 24 juin 2020 portant introduction d'une série de mesures concernant les activités sportives, les activités culturelles ainsi que les établissements recevant du public, dans le cadre de la lutte contre la pandémie Covid-19*, Journal officiel du Grand-Duché de Luxembourg Mémorial A 525 du 24 juin 2020, Luxembourg.

IGSS (Inspection Générale de la Sécurité Sociale, 2019), *Rapport général sur la Sécurité Sociale 2018*, Luxembourg.

IGSS (Inspection Générale de la Sécurité Sociale, 2020a), *La Sécurité sociale 2020, Code de la sécurité sociale*, Luxembourg.

IGSS (Inspection Générale de la Sécurité Sociale, 2020b), *Rapport général sur la Sécurité Sociale 2019*, Luxembourg.

Ministère de la Famille, de l'Intégration et à la Grande Région (2020), *Rapport d'activité 2019*, Luxembourg.

Ministère de la Sécurité sociale (2009), *L'Assurance Dépendance - Guide pratique, Cellule d'évaluation et d'orientation de l'assurance dépendance*, Luxembourg. Available at http://sante.public.lu/fr/publications/a/assurance-dependance-guide-fr-de-pt-en/assurance-dependance-guide-fr.pdf.

Nati-Stoffel, Marianne (2015), *Social dialogue in Luxembourg* - An article prepared for the AICESIS Newsletter, CES. Luxembourg.

OECD (2019), *Health at a Glance 2019: OECD Indicators*, Paris.

OECD/European Observatory on Health Systems and Policies (2019), *Luxembourg: Country Health Profile 2019, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

Pacolet, Jozef & De Wispelaere, Frederic (2018), *ESPN Thematic Report on Challenges in long-term care, Luxembourg*, European Commission. Available at https://ec.europa.eu/social/BlobServlet?docId=19858&langId=en.

◂ back to table of contents

Urbé, Robert (editor, 2012), *The Future of the Welfare State – A comparative study in EU-countries*, A Caritas Europa Publication, Freiburg i.Br.

Urbé, Robert (2013), *Los herederos de Bismarck no tienen futuro? Origen y perspectivas del modelo de bienestar alemán*, in Documentación social, Revista de Estudios Sociales y de Sociología Aplicada, N° 169, Madrid.

Urbé, Robert (2020), *Luxembourg: Consequences of a general economic downturn due to the COVID-19 pandemic*, ESPN Flash Report 2020/24, European Social Policy Network (ESPN), Brussels: European Commission.

◂ back to table of contents

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