Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Luxembourg

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Content

Summary of Main Findings

Representative organisations of family carers and older people

- ALA (Association Luxembourgeoise Alzheimer; Luxembourg Alzheimer Association)
- ALGG (Association Luxembourgeoise de Gérontologie / Gériatrie; Luxembourg Gerontology / Geriatric Association)
- Conseil Supérieur des Personnes Agées (Higher Council for Older People)
- COPAS (Confédération luxembourgeoise des Prestataires et Ententes dans le Domaine de Prévention, d'Aide et de Soins aux Personnes dépendantes; Luxembourg Confederation of Service Providers and Associations of Prevention, Assistance and Care for Dependent People)
- EGIPA (Entente des Gestionnaires des Institutions pour Personnes Agées; Association of Managers of Old Peoples' Home Institutions)
- OMEGA asbl (Service for Training in Palliative Care)
- Service socio-familial RSB (RSB Socio-Family Service)
- Organisations of family carers:
  - None
- Organisations of older people:
  - AMIPERAS (National Association of Older Citizens): The national AMIPERAS is an umbrella association of local and regional AMIPERAS sections, run by older citizens themselves and organising social, leisure and cultural activities for senior citizens of the area. The local municipalities support the AMIPERAS financially.
  - LRIV (Letzeburger Rentner- an Invalideverband; Luxembourg Association of Retired and Invalid People)
  - "Clubs Senior" – "Centres Régionaux d'Animation et de Guidance pour Personnes Agées" (Regional Centres Offering Animation and Guidance for Older Citizens). The "Clubs Senior" are organizing and offering social, leisure and cultural activities, as well as meals, and counselling services on various issues (e.g. preparation on retirement, physical and mental health). Additionally, the Clubs Senior are characterised by an intergenerational profile; activities are not identical between the various clubs but much more sensitive to the local and regional particularities.

Service providers

- "Hëllef Doheem" (Help at Home)
- "HELP" (support, care)

Policy makers

- Ministère de la Famille, de la Solidarité Sociale et de la Jeunesse (Ministry of Family Affairs, Social Solidarity, and of Youth); since July 2004 Ministère de la Famille et de l'Intégration (Ministry of Family Affairs and Integration)
- Ministère de la Santé Nationale (Ministry of National Health)
- Ministère de la Sécurité Sociale (Ministry of Social Security)
- Conseil Supérieur des Personnes Agées (Higher Council for Older People)
- Conseil Supérieur des Personnes Handicapées (Higher Council for Handicapped People)
- "Conseil Supérieur du Bénévolat" (Superior Council of Volunteer Activities) and a "Agence du Bénévolat" (Agency of Volunteer Activities) have been established in September 2002. The council has the tasks of encouraging and promoting volunteer activity and to inform policy makers on these activities. Furthermore, it is responsible for the coordination of existing initiatives. The Agency of Volunteer Activities has been active since June 2003 and has realized a survey on the need of volunteer activities, and is at time creating a data bank about types of activities, specific needs for volunteer activities, as well as contact addresses.

Introduction – An Overview on Family Care

Demographic trends related to family care-giving in Luxembourg. Comparable to all other Western-European countries the demographic changes in Luxembourg are characterized by a progressively declining and low birth rate, greater longevity and increasing female participation in the paid several outstanding labour market. Although comparable to its neighbours, Luxembourg has characteristics, the *first* one being the relative small population which runs to a number of 451,600 persons, who speak up to three languages (Luxembourgish, French and German). Table 1 summarizes a first break down of the total population in its absolute and relative numbers of women and men in three age groups using data form the population census 2001 provided by the National Statistical Bureau of Luxembourg STATEC.

Table 1: Age groups and sex ratios as estimated by population census in January 2001 in Luxembourg

Population census	Total	Male	Female	Sex Ratio (male / female)
Children (0 to 14 years)	84,780 18.8 %	43,599 19.5 %	41,181 18.0 %	1.06
Active age (15 to 64 years)	303,165 67.1 %	153,457 68.8 %	149,708 65.5 %	1.02
Third age (65 years and older)	63,655 14.1 %	25,964 11.6 %	37,691 16.5 %	0.69
Total	451,600	223,020	228,580	

(Source: STATEC, 2003)

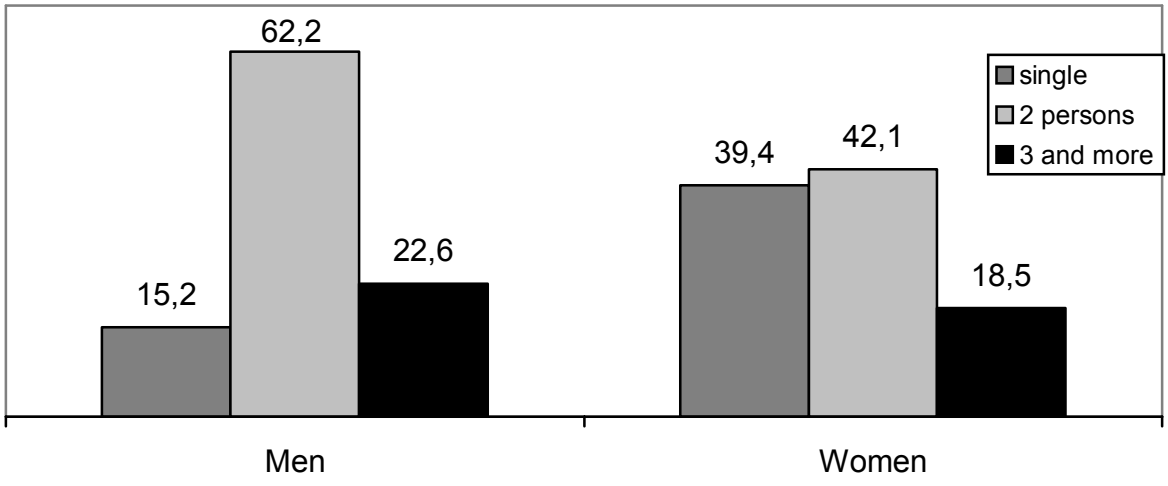
These data illustrate that the ratio of children and the “third age” is still in Luxembourg in favour of the first group; present estimations show that the death rate amounts to “8.42 deaths per 1,000”, the birth rate averages “12.21 births per 1,000” resulting in a general population growth rate of 1.28. Life expectancy at birth averages 77.3 years, the average for the male subpopulation being 74.9 years and 81 years for the female subpopulation respectively. The relative small population is distributed in rural and urban areas, whereas the industrialized South of Luxembourg represents the most populated part of the country.

A further distinctive feature of the Luxembourg population is its relative high amount of foreign persons, which has progressively grown during the last twenty years. The current ratio of native Luxembourgish to foreign persons amounts to 1.68 whereas native Luxembourgish stand for 61.9 % and foreign persons for 38.1 % of the total population respectively. Within the latter group, persons of Portuguese origin represent the largest part (61.4 %), followed by the French (21.6 %), and Italian nationality (19 %; see Annexe).

Eurostat (2004) reports that GDP per capita was $ 49,100 (in terms of purchasing power standards; PPS) in 2002 being more than twice the EU25 average. High economic standard is due to a stable, high-income economy, characterized by solid growth, low inflation, and comparatively low unemployment. Luxembourg thus represents a wealthy country where life expectancy will heighten for men and even more pronounced for women in the years to come. Policy makers have reacted to this comparable to other Western-European countries by a legal act in 1998 where the dependency insurance was decided and conditions for its establishment were elaborated. Parallel to this, care institutions, like nursing homes and especially home care facilities have been developed during the last years.

The family network. Quantitative and qualitative indicators can in general be used to describe the family network. The first one includes more or less objective parameters such as proximity and distance between family members, frequency of contacts, whereas the latter comprise the subjective evaluation of the network in terms of individual satisfaction with social contacts, perceived emotional closeness and so on (see 1.1.8 on this issue). Concerning quantitative characteristics Luxembourg again holds an interesting position since the distance between family members is due to the small area of the country (2,586 sq.km) comparatively low. According to STATEC's population census from 2001 a proportion of 15.2 % of the men above 65 years live alone, whereas 62.2 % live in a household with two persons and 22.6 % in a household with three or more persons. These ratios change considerably with respect to women of 65 years and older: Here, a greater proportion of 39.4 % live alone, compared to 42.1 % living with another person and 18.5 % living with three or more persons. Clearly these ratios do shift across age groups with more persons living alone (for details see Annexe 7.1.5).

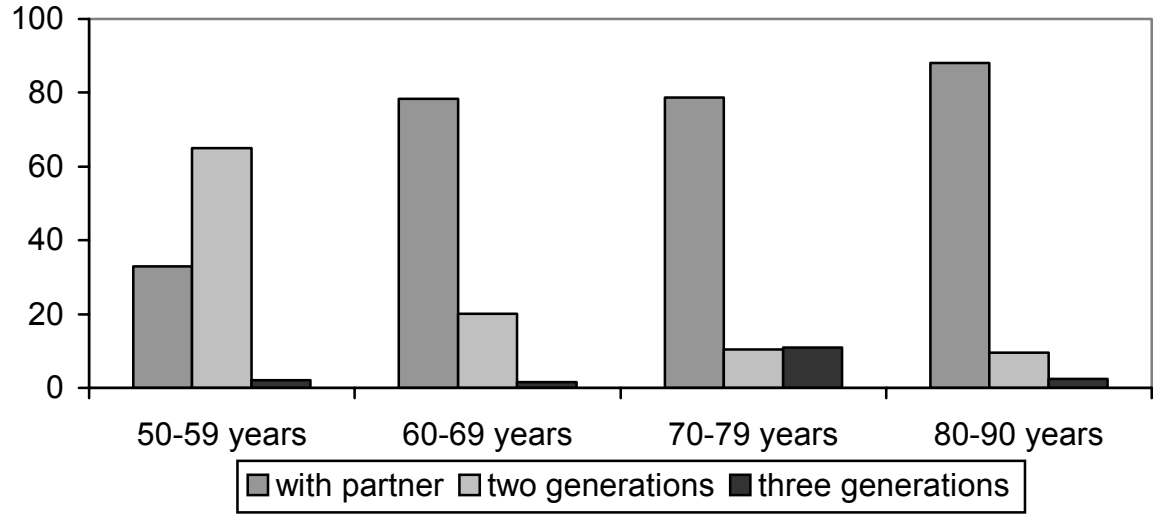
Figure 1: Household composition of men and women of 65 years and older in 2001



(“,” means “.”, e.g. 62,2 = 62.2)

Data from the *"European Study on Adult Well-being*" (ESAW), funded by the European Union and conducted at the University of Luxembourg during 2002 and 2003, can be used to specify the situation of family networks in Luxembourg (see Ferring et al., 2004). The data stem from a representative sample of 2,175 persons living independently (*not hospitalised*) in the age range of 50 to 90 years and show *in general*, that the probability of living alone clearly increases across age groups the proportion of women living alone being more pronounced: 85 % percent of persons living alone in the age group between 70 and 79 years were female, within the group of persons between 80 and 90 years this proportion amounted to 86 %. An inspection of household composition with respect to different generations living together is depicted in figure 2. Here it gets evident that there is a decrease in two and three-generation-households across age. On the level of the total sample 59 % of the respondents live with his or her partner, 38 % live in a two-generation-household with partner and children, only 3 % live in a three-generation-household with partner, children and grand-children. (See also below "Profile of family carers" as well as the Annex.)

Figure 2: Household composition in terms of generations living together in a representative Luxembourg sample (Ferring, 2005)



Public care service provision in Luxembourg. Dependency insurance ("*Assurance dépendance*") was introduced in Luxembourg by law of 18th June 1998, in vigour since 1st of January 1999, where dependency and need for care are listed as a further risk to social security besides disease, work accidents, invalidity and ageing (see Ministère de la Sécurité Sociale (Ministry of Social Security), 2004). The insurance aims at a compensation of the costs that are generated by *the need for assistance and care by a third person, who helps to maintain and guarantee the basic acts of living in a state of dependency*. The latter comprise the bodily hygiene, nourishment and

alimentation, and mobility. Dependency is defined as *a living condition, where a person - due to a physical, mental or psychiatric illness or deficiency of a similar nature regularly needs a considerable amount of assistance from a third party in order to carry out basic daily tasks (at least 3.5 hours per week)*. The tasks of such a third person are defined as assisting and supporting the dependent person in performing the basic acts of living or performing partially or totally these acts for the dependant person.

Services are available for persons still living at home as well as persons living already in a residential home or nursing home. There is no qualifying period for the services of dependency insurance, except for those persons, who contracted an optional insurance, and who are entitled to benefits only after a one-year qualifying period. Accumulation with benefits of accident insurance and compensation benefits of war victims is not possible. There is no taxation of the benefits and a participation of the beneficiary is *not* foreseen; the amount of the benefit varies according to the degree of dependency.

In order to get benefits from the dependency insurance the need for aid and care has to be significant and on a regular basis, which is estimated with a minimum of 3.5 hours per week. A public service centre – "*Cellule d'évaluation et d'orientation*" (CEO) - has been established under the lead of the *Ministry of Social Security*, whose tasks comprise beside others the estimation of the need for care and the corresponding attribution of benefits by the dependency insurance. The final decision on the establishment and amount of services based on the advice provided by the CEO is taken by the "Union of Sickness Funds" ("*Union des caisses de maladie*"), which constitutes the second pillar of the dependency insurance. The activity profile of the union comprise (1) the individual classification of dependency, as well as the attribution, reduction, and suppression of the different benefits and services, (2) the payment of nursing services, the elaboration of nursing contracts, and the negotiation of the monetary value of nursing services, (3) the negotiation with services for the provision of nursing aids.

The care "market" in Luxembourg. *There is no irregular care market in Luxembourg*, since two foundations "Hëllef Doheem" (Help at Home) and HELP (for a detailed description see Annex) are in charge of aids and services within the framework of dependency insurance. In the case of persons still living at home, both networks are directly contacted by the Union of Sickness Funds as soon as a decision on the amount and scope of services has been taken (see also Case management); a coordinator then visits the dependant person and her or his significant others in order to discuss and if necessary modify the service plan. The networks do provide all services covered by the dependency insurance and directly discount their services with the Union of Sickness Funds. Presently, there are no private care organizations in Luxembourg, since the payment for all services provided by the dependency insurance is regulated be the law June 18th 1998 and its amendments, which foresee the abovementioned networks as (only) contacts.

The law also arranges, that – besides the services provided by the networks - the dependant person receives a nursing allowance of € 23.85 per hour. The beneficiary can dispose of this money to finance an informal caregiver, who may be best described as significant other, being it the spouse, offspring, other kin or friends. Three further specifications exist: If the estimated amount of care is less than seven hours per week the beneficiary may use the allowance completely for an informal caregiver. If the amount ranges between seven and 14 hours, help networks must provide at least the half of services; finally, services exceeding 14 hours per week have to be completely provided by the help networks.

Furthermore, the person in need for care receives each year the double amount of his or her nursing allowance. This should be used to finance a *stand-in person for three weeks* during a year and give the informal carer time for recreation. Additionally, *temporary stays in a nursing home* are directly financed by the dependency insurance. *The family carer himself or she will not get any direct benefits* with the exception of a contribution to pension funding (see below). According to statistics provided by the Ministry of Social Security (2003) a total of 467 persons were in charge as informal carers in June 2003 (see point 1).

Informal unpaid care in Luxembourg. Specific data on informal care provision are not available for Luxembourg, but one may use the availability of volunteer organisations as a crude indicator describing the potential for voluntary aids.

Up to 23 associations on a volunteer basis are registered by the Ministry of Family Affairs (2003), which are spread across the country and offer services ranging form small repairs to visiting elderly in residential homes. Altogether, there has been a strong initiative by this ministry to encourage volunteer activities in the area of caring during the last ten years. A “Conseil Superieur du Bénévolat” (Superior Council of Volunteer Activities) and an “Agence du Bénévolat” (Agency of Volunteer Activities) have been established in September 2002. The council has the tasks of encouraging and promoting volunteer activity and to inform policy makers on these activities. Furthermore, it is responsible for the coordination of existing initiatives. The Agency of Volunteer Activities has been active since June 2003 and has realized a survey on the need of volunteer activities, and is presently creating a data bank about types of activities, specific needs for volunteer activities, as well as contact addresses. Furthermore, several contact and information meetings have been taken place with Belgian and German associations; the Luxembourg agency is member of the “Centre Européen du Volontariat” (European Centre for Volunteer Activities).

Estimated needs for care. National data on estimated need stem from the Household Panel for 1996, which was conducted before the introduction of the long-term care insurance and certainly has to be updated in the future. According to this source 4.3 % of the households had a dependent person (sick or with a disability and in need of care) at home. In almost one out of two

cases (nearly 50 %, or half), this was an older adult (65 or older); in 41.5 % of the cases it was a younger adult (18 to 64); and in 13.2 % children.

The estimated need for care will be calculated in the following by using two data sources: Data from the annual report of the Ministry of Social Security (2003), which highlight the development of demands within the framework of the dependency insurance since its implementation in 1998, and population data provided by STATEC (2003). According to the Ministry report a total of 27,976 demands have been registered during the five years since the implementation of dependency insurance. Of these 89.4 % percent were submitted concerning persons older than 60 years. A total of 17,933 demands have been accepted and of these 90.1 % have been submitted for persons older than 60 years, 83.2 % of these concerned persons being older than 70 year. A proportion of 62.6 % of the accepted applications (n=11,228) did refer to the care of persons at home, and 37.4 % (n=6,705) referred to persons in nursing homes. With respect to gender it did show that the majority of applications have been submitted for women (n=12,107; 67.5 %).

Table 2: Estimated need for care in persons older than 60 years

Age group	Population (P)	Demands (D)	Proportion (D / P)	Accepted demands (A)	Proportion (A / P)	Care at home (C)	Proportion (C / P)
≥90	1,987	1,189	59.84	826	41.57	745	37.49
80-89	12,130	2,126	17.53	1,378	11.36	1,242	10.24
70-79	31,004	1,247	4.02	783	2.53	705	2.27
60-69	39,491	389	0.99	246	0.62	222	0.56
Total	82,625	4,952	5.99	3,233	3.91	2,913	3.53

Relating the applications within the age groups with population data, several estimates of persons in need were calculated for the time-span of five years since the introduction of the dependency insurance (see Table 2). When weighting the *total* of applications with population data, a proportional need of 6 % of the total population above sixty years did result. Taking the *accepted* applications, the total amount of need was estimated with 4 % of the population above 60 years; the need being highest in the group above 90 years (42 % of the population), followed by 11 % of the population in the group between 80 and 89 years, 2.5 % in the group between 70 and 79 years, and 0.6 percent in the group between 60 and 69 years of age.

With respect to demands accepted for domiciliary care a proportional need of 3.53 % illustrates the overweight of demands concerning these services and aids. The estimates on the basis of the accepted demands also correspond with the abovementioned data from the Household Panel (1996).

***Financial situation of health and long-term care insurance*.** Despite the evident wealth of Luxembourg, the *Union of Sickness Funds* has reported a deficit of 50 Million Euro for 2004, which had been compensated for by a 130 Million

Euro transfer from the pension fund; projections for 2005, nevertheless, indicate a growing deficit of 100 Million Euro. This reduction is due to increasing costs for services such as doctor bills, hospital expenses, and charges for medication, which were caused by an increase in honorary charges for several medical partners, a new collective agreement for nursing personnel as well as the opening of new hospitals (see Feist, 2004a). A decrease in foreign workers in 2003 and 2004 represents a further critical factor, since the Union takes advantage of a relatively young foreign labour force in Luxembourg, who only use the medical services to a little degree compared to the national population. While the number of foreign workers has increased in 2000 by 11.8 % and in 2001 by 11.4 %, the number decreased in 2003 to 5.8 % and in 2004 to 4.3 %; at the same time the increase of costs of the Union amounted to 8 %. Increasing contributions, reduced services, and / or a stronger individual contribution and forehandedness will certainly be discussed for the provision of health insurance services in the years to come in Luxembourg as well.

Socio-political discussion of ageing and care policies. Concerning the political discussion about the significance of services for the elderly, the most current government program (Luxembourg Government, 2004) may be cited here. The year 2004 has been a year of the national elections in Luxembourg, and the Christian-Social Party (*Parti chrétien-social*; CSV) and the Luxembourg Socialist Workers Party (LSAP; *Parti ouvrier socialiste luxembourgeois*) form the new government; before this election the government was formed by a coalition of the Christian-Social Party and Liberal Democrats. Both governments did and do put great emphases on the development of services for the elderly be it the elaboration of residential and nursing homes or be it the elaboration of structures concerning care at home services (see also point 2). The agreement of coalition, which has been published on July 26th 2004, relocates the responsibility for policy concerning the elderly especially to the newly defined “Ministère de la Famille et de l’Intégration” (*Ministry of Family Affairs and Integration*). Several points are highlighted in the Ministry’s declaration concerning politics for the elderly, and the development and amelioration of measures concerning *home care* as well as the development of residential and other structures for the elderly are named on the first position here. The need for a further development not only of geriatric but also of *gerontological rehabilitation*, as well as the development of legal measures to ascertain the rights of persons with psycho-geriatric troubles represent further important points. Special attention is also given to the development of palliative care be it the establishment of respective structure be it the professional training and formation in this area. A final important point in the Ministry’s declaration concerns the necessity and the encouragement of care personnel, who do originate mainly from neighbouring countries and new European emigration countries, to learn Luxembourgish. Summarizing, one may characterize the endeavours of the ministry by the objective to encourage

measures, which help ageing persons to live independently as long as possible at home thus realizing a social inclusion-approach.

National specifics. Two national characteristics may be mentioned here havin direct consequences for the care market: First, the comparatively high proportion of foreign labour forces in Luxembourg, and second the multilingualism of Luxembourg's society. Besides Luxembourgish as national language, French and German are other official languages. These three languages are commonly used in everyday life with many people having high competencies in expressing themselves in these three languages, with one exception: the older generation being raised and educated during the NAZI-occupation of the country, a time when teaching and speaking French was prohibited (even people's first names, when showing to be of French origin, were changed to German language first names). Within the caring sector, this is eventually a major issue and challenge, as French-speaking personnel from Portuguese, French, and Belgian origin do represent the vast majority of foreign care workers, thus aggravating the communication for many dependant older people of Luxembourg origin.

Furthermore, a shortage in nursing personnel may be expected in the long run (see Feist, 2004b): While in the years 2001 and 2002 a total of 200 to 230 inscriptions had been registered in the National School for Nursing Personnel (*Lycée Technique pour Professions de Santé*), the latest number of inscriptions did amount to 90. With the emphasis put on nursing and residential homes, as well as the elaboration of care at home and programs aiming at palliative care the number of nursing personnel will certainly increase in the years to come. Between 1999 and 2003 the number of necessary nursing personnel increased from 2,425 to 2,657, leaving a difference of 130. Foreign personnel compensated these, because the income for nursing personnel in Luxembourg is comparatively high (starting from € 2,589 up to € 4,906; Feist 2004b). Since these do mainly originate from countries with Romance languages (i.e., Belgium, France, Portugal) it is not surprising that the present government puts so much emphasis on the acquisition of the Luxembourgish language.

1 Profile of family carers of older people

Statistics concerning persons being involved in family care are provided to a certain degree by the annual report of the Ministry of Social Security (2003); these are summarized in Table 3 for the time-span between 1999, when the dependency insurance was implemented, and 2002. A total of *464* persons are engaged in the care of a family member comprising 437 *women* (94.2 %) and 27 *men* (5.8 %); the total number of 464 informal carers corresponds to a proportion of 0.1 % of the total Luxembourg population. The mean *age* of caregivers amounts to 43.7 years.

Table 3: Absolute and relative number of persons involved in family care between 1999 and 2002 in Luxembourg (Ministry of Social Security, 2003)

Age group	1999	2000	2001	2002	Total
15-19	1	0	0	0	1
	0.5	0	0	0	0.2
20-24	1	3	1	0	5
	0.5	3.1	1.3	0	1.1
25-29	15	3	5	3	26
	6.9	3.1	6.3	4.2	5.6
30-34	24	12	10	10	56
	11.1	12.2	12.7	14.1	12.1
35-39	37	23	9	13	82
	17.1	23.5	11.4	18.3	17.7
40-44	36	14	16	13	79
	16.7	14.3	20.3	18.3	17
45-49	37	12	11	11	71
	17.1	12.2	13.9	15.5	15.3
50-54	36	18	12	14	80
	16.7	18.4	15.2	19.7	17.2
55-59	17	11	10	5	43
	7.9	11.2	12.7	7	9.3
60-64	12	2	5	2	21
	5.6	2	6.3	2.8	4.5
Total	216	98	79	71	464
	(46.6)	(21.1)	(17)	(15.3)	

Table 3 also illustrates the development in the number of informal caregivers across four years. The majority of these (46.6 %) have been registered in the first year of dependency insurance installation; after 1999 the number of new family carers decreased and averages around 83 persons. The comparatively

small number of family carers as well as the comparatively small increase across the years may also help to explain why there are no organisations such as self-help group of family carers in Luxembourg.

1.1 Number of carers

N=464

1.2 Age of carers

M=43.7 years

1.3 Gender of carers

437 women (94.2 %), 27 men (5.8 %)

1.4 Income of carers

Unknown.

1.5 Hours of caring and caring tasks, caring for more than one person

Statistics on the hours of caring are summarized by the report on dependency assurance provided by the Ministry of Social Security (2003); these are depicted in the following table and describe the situation at June 30th 2003. Since these are the services provided for the dependant person one gets also a crude estimate about the amount of supplementary care to be realized by informal carers. The total number of hours given in table 4 summarizes all services, provided by the networks, which do comprise (1) help with the basic acts of living (concerning bodily hygiene, nutrition, mobility), (2) domestic tasks such as cleaning and washing, and (3) support in promoting activity and preventing an increasing dependency such as the encouragement of individual preferred activities or group activities. A maximum allowance of 24 hours per week is foreseen for help with basic acts of living for persons living at home, for persons living in homes the total number of hours can be raised by 25 %; domestic helps are supported with an upper limit of 4 hours per week, and support activities are financed to a maximum of 12 hours per week.

Table 4 shows that 65 % of the beneficiaries did use the total of services to a temporal amount under 24 hours per week; this group comprised 70 % in 2001 and 67 % in 2002, describing a decreasing trend. A proportion of 35 % of dependent persons were in need of services, which exceeded 24 hrs, within these 14.1 % needed more than 34 hrs of help. The mean time was 21.2 hrs in

2003, and compared to 2001 this mean value has increased by nearly two hours (Ministry of Social Security, 2003).

Table 4: Breakdown of total hours of caring per week by age (Ministry of Social Security, 2003)

Hours	Number of beneficiaries	Percentage
3.5-13.99 hrs	2,583	38.5
14-23.99 hrs	1,775	26.5
24-33.99 hrs	1,393	20.8
34-43.99 hrs	499	7.4
44-63.99 hrs	311	4.6
64-83.5 hrs	142	2.1
Total	6,703	100.0

Number of hours is further specified with reference to different age groups in the following table; the highest amount of time was spent with persons within the age group between 19 and 40 years (25.4 hrs per week), since these comprise persons with severe handicaps in need of a high amount of care. Persons over 90 years represent the second group with a pronounced need of care (22.8 hrs per week), followed by the old-age groups of 80-89 years (21.7 hrs per week) and of 70-79 years (21.1 hrs per week). Taken into account, that 73.7 % of the beneficiaries are 70 years or older, these data clearly indicate a positive correlation between age and need of care indicated here by hours of caring.

Table 5: Breakdown of hours of caring by age group (Ministry of Social Security, 2003)

Age groups	Hours per week	Number of beneficiaries	Percentage
90-109	22.8	1,023	15.3
80-89	21.7	2,341	34.9
70-79	21.1	1,573	23.5
60-69	18.3	581	8.7
40-59	19.7	556	8.3
19-39	25.4	298	4.4
0-18	17.3	331	4.9
Total	21.2	6,703	100.0

Although the official statistics do not convey information about the amount of time spent by informal carers, they allow nevertheless an extrapolation, indicating that the most of the informal carers in Luxembourg are in charge for the elderly, whose need for aid and help is quite pronounced. Certainly, further research on this issue is absolutely necessary here.

1.6 Level of education and / or Profession / Employment of family carer

No statistics available.

1.7 Generation of carer, in relation to OP. Relationship of carer to OP

More than 80 % of the total demands (n=22,185) and accepted demands (n=17,933) within the five years after the installation of dependency insurance were requested for persons older than 70 years, between July 2002 and July 2003 this proportion was 86 % (see Table 6). Extrapolating from these data, as well as the mean age (M=43.7 years) and the predominant gender of informal carers, one may thus hold that in most of the cases, the *grown-up daughters in middle adulthood* do care for their elderly parents.

Table 6: Number of accepted demands by the dependency insurance for five-year- and 1-year-time span

Age group	Five years		1 year	
	Absolute	Relative	Absolute	Relative
100-109	169	0.9	143	2.8
90-99	3,963	22.1	2,014	39.4
80-89	6,891	38.4	1,668	32.6
70-79	3,914	21.8	718	14.0
60-69	1,230	6.9	150	2.9
50-59	575	3.2	114	2.2
40-49	371	2.1	105	2.1
30-39	215	1.2	46	0.9
20-29	163	0.9	45	0.9
10-19	232	1.3	83	1.6
0-9	210	1.2	29	0.6
Total	17,933		5,115	

1.8 Residence patterns

Data on household structure have been reported above showing that the better part of men in the population over 65 years lived in a two-person household (62.2 %), whereas this was only the case for a smaller proportion of women (42.1 %); here a higher proportion of 39.4 % lived alone compared to a percentage of 15.2 % in the male population. With respect to housing, statistics provided by STATEC for 2001 are described in the following table.

Here it gets evident that the better part of persons over 65 years and older in Luxembourg owns a housing of their own: A total percentage of 82 % across

the age groups of 65 years and older live in property of their own, followed by 3.1 % who profit from a rent-free lodging. A proportion of 15 % of the total population has to pay a rent, and this proportion increases across the age groups starting with the age of 80 years and over indicating that the elderly choose smaller accommodations, which are more easily to handle.

Table 7: Kinds of housing across age groups above 65years in Luxembourg 2001

Age groups	Own property	Rent free lodging	Lodger	Total
65-69	83.3	2.2	14.5	18,317
70-74	83.7	2.7	13.6	17,151
75-79	81.1	3.6	15.3	11,400
80-84	77.5	4.6	17.9	5,962
85-89	76.8	4.7	18.5	3,244
90-94	74.9	5.3	19.8	997
95-99	79.5	5.3	15.2	151
≥100	50.0	12.5	37.5	8
Total	81.9	3.1	15.0	57,230

With respect to proximity of family members, data from the ESAW will be used in the following to give a more general view of this. Respondents had been asked "*If you have any children, where does your nearest child live?*". A total of 1,929 persons (90 %) had children, and 50.8 % of these reported that the nearest child lived in the same house or within one km, followed by 22.6 % reporting a distance of 1-5 km to their children. Only 8 % reported a distance between 16 and 50 km, and a minority of 3 % reported a distance over 50 km. With respect to the size of Luxembourg these results are not astonishing and indicate all in all a high proximity between the generations.

Since these quantitative statistics do not qualify the relationship, a last item from the ESAW will be used here, which explored the *satisfaction* with family relations on a five-point scale. The majority of the samples in all age groups reported here to be moderately or highly satisfied averaging to 90.6 % of the total sample.

Table 8: "How satisfied are you with your family relationships?"

Category	50-59 years	60-69 years	70-79 years	80-90 years	Total
Highly dissatisfied	18 2.4 %	13 1.6 %	11 2.9 %	12 6.5 %	54 2.5 %
Moderately dissatisfied	29 3.9 %	27 3.3 %	20 5.3 %	5 2.7 %	81 3.8 %
Undecided or neither	25 3.4 %	19 2.3 %	14 3.7 %	8 4.3 %	66 3.1 %
Moderately satisfied	332 45.0 %	308 37.2 %	120 31.6 %	47 25.4 %	807 37.9 %
Highly satisfied	334 45.3 %	461 55.7 %	215 56.6 %	113 61.1 %	1,123 52.7 %
Total	738 100.0 %	828 100.0 %	380 100.0 %	185 100.0 %	2,131 100.0 %

Taken together, one may summarize that quantitative as well as qualitative indicators indicate a high level of own property, a close proximity as well as a high satisfaction with family relations. It goes without saying that these results have only a general character and have to be qualified with respect to the relation of informal carer and the dependant person.

1.9 Working and caring

See 2.2.3.

1.10 General employment rates by age

Present statistics of the STATEC (2003) report an unemployment rate of 3.9 % (8,026 persons) in June 2004, the rate being higher (5.1) for women than men (2.7). The *total employment rate* reported in 2002 for the age group between 15 and 64 years was 75.6 % for men and 51.6 % for women, the mean rate in the EU15 being 72.8 % for men and 55.6 % for women respectively. With respect to *full time employment*, the rates were 76 % for men and 45.7 for women. Within the age group between 55 and 64 years, the employment rate was 37.9 % for men and 18.6 % for women. Compared to the EU15 mean values of 50.1 % for men and 30.5 % for women, Luxembourg clearly shows a lower employment rate within this age group. This corresponds with the low mean retirement age, which is 56.8 years in total, and 57.5 years for men and 55.3 years for women.

1.11 Positive and negative aspects of care-giving

No statistics available on this issue and it is thus object to further research.

1.12 Profile of migrant care and domestic workers (legal and illegal)

In general, one may cite here again the comparatively large impact of foreign labour force on the Luxembourg work market, which has been described above under country specific issues. A total of 273,427 persons is employed in Luxembourg according to STATEC (2003), of these 167,765 persons are living in Luxembourg, 105,662 are foreigners, entering the country daily for their work, the so called “frontaliers”. Persons resident in Luxembourg can further be differentiated with respect to Luxembourgers (93,182; 55.5 %), persons form the EU (65,817; 39.2 %) and persons from outside the EU (8,766; 5.2 %). The foreign work forces do compose as follows: 55,633 (52.7 %) of French nationality, 29,007 (27.5 %) of Belgian nationality and 21,022 (19.9 %) of German nationality.

This general finding can be crudely specified with respect to the sector of education, health, and social services in March 2003: A total of 25,485 persons being occupied within this sector were reported for 2003. Of these 45.5 % were Luxembourgers, followed by 26.4 % foreigners living in Luxembourg. The number of non-residential employees (7,168; 28.1 %) comprises 3,688 French (14.5 %), 1,706 Belgian (7.4 %), and 1,706 Germans (6.7 %). If one takes into consideration that the domain of education is to the majority covered by Luxembourgish personnel, the data indicate that in the domain of health and social services more than the half of the personnel is of foreign origin.

1.13 Other relevant data or information

No information nor data provided.

2 Care policies for family carers and the older person needing care

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

Care policy for family carers has been formally implemented by the 1998th act "Assurance Dépendance": Under this framework the financial provision for professional care is secured and additionally, care services delivered at home by a family member or other informal carer to a dependent relative are for the first time recognized on the basis of a financial compensation. Thus, the dependency insurance covers the costs of care for a dependent person; these services are independent of the place where the older dependent person is living. The payment of care services delivered by family members to a dependent relative as introduced by this act, additionally promotes the "*aging at home approach*" for dependent people, a policy adopted by the Government in recent years within the general policy for older people. This chapter will focus on the changes in the care policies for family members, first, briefly depicting the elements of the traditional care system with some of its characteristic structural and philosophical-ethical features, and secondly, focusing on new frameworks aiming at meeting the challenges of an ever growing older population.

2.1.1 What are the expectations and ideology about family care? Is this changing?

The framework of national policies with regard to dependent older people has changed during the last decades from the *social exclusion model*, characterised mainly by a few large special institutions for older people, either older peoples homes or nursing institutions, to a model of *social inclusion* with a broader variation in service structures as well as in a wide spread system of support. The vast majority of the institutional structures and the services continue either to be *publicly managed* or they are run by *non-for profit-organisations* as institutions with a public utility and are thus indirectly publicly controlled, with the government or the municipalities supporting the annual running costs of these institutions, as the monthly fees the residents are paying do not cover all the costs of the institutions. Systems of support for older and dependent persons, run on a private business scale, have emerged only since the introduction of the dependency insurance.

Major recent advances: From the beginning of the 1990s new approaches have emerged on the map of service provisions for older dependent people in Luxembourg. The timing of the beginning of the restructuring and adaptation of

the services for the older generation was triggered by at least two major factors:

- The United Nations Principles for Older Persons, adopted by the UN General Assembly in 1991 (UN, 1991) and the action program on aging for 1992 and beyond as outlined by the UN secretary-general, including the development of a practical strategy on aging for the decade 1992-2001 and promotional activities, such as the annual observance of October 1st as International Day for the Elderly. These global initiatives triggered by the first World Assembly on Aging, held in Vienna 1982 (World Assembly on Aging, 1984), with the UN General Assembly endorsing the Vienna International Plan of Action on Aging and culminating in 1999 in the UN Year of Older Citizens with the closing Second World Conference on Aging in Madrid 2002 (UN, 2002), showed to have a high influence on the national level with working towards a national agenda on aging issues, and,
- a very healthy national economy. The political decision for change in the aging policies, accompanied by broader public awareness campaigns to the aging issues, was indeed favoured by very wealthy dynamics in the national economy, with yearly economic growth rates being among the highest within the countries of the EU for the last twenty years. Till 2002 the yearly national budget was marked by substantial annual surpluses, allowing the national government to make investments in a large variety of projects, among others the restructuring of the system of supports in the aging arena.

First, a reorganisation of the publicly managed older people homes and special institutions has been undertaken, with the creation of so-called “Centres Intégrés pour Personnes Agées” (Integrated Centres for Older People, see also below). In addition, small-scaled community based homes and day centres for dependent older citizens or people with dementia have been set up. Such projects, though initiated in general by activities of local NGOs, have been financed by the Ministry of Family Affairs, Social Solidarity and Youth by so called conventions, i.e. yearly renewable contracts. Later, the general financing of care provisions was reviewed and parliament voted on June 18th 1998 the act on dependency insurance, a model nurtured by ideas both from the Canadian and the German model. Parallel to the introduction of the dependency insurance the traditional Luxembourgish model of caring for the dependent family member at home was strongly promoted by setting up and extending a country wide respite care system being “Hëllef Doheem” (Help at Home) and “HELP”, acting nowadays as the main players. Thus, the formal policies for dependent older people has in some way come back to the roots: Caring and serving for the dependent older citizens as long as possible at home is strongly promoted, with offering professional support to family carers financed through a genuine legal framework. In addition, the institutionalised settings offering care for the elderly dependent have been

reformed mainly to integrated centres for older people, new centres have been set up, thus offering a capacity that considers the dynamics of the change in the demographic structure, and, most important, defining and implementing a quality management system assuring, rights and dignity for dependent people, nurtured by professional competences and skills, which aim at an evidence based foundation.

Central position of the Ministry of Family Affairs, Social Solidarity and Youth: Within the ageing field the Ministry of Family Affairs, Social Solidarity and Youth has the major position, covering a large agenda affecting the quality of life of the country's inhabitants through all the ages. The Ministry is legally responsible for the system of supports for older and dependent people and acts in this field as the main conductor: planning the national program, supporting selected projects as designed and suggested by local initiatives, and being the main financier for new projects and established service provisions offering supports for old age and especially dependency in old age. In addition to the Ministry's role and responsibility in the direct support and care of dependent older citizens its overall position as the leading actor in the field for older citizens can best be described by following examples: The "Radio Socio-Culturelle", a social-cultural radio station run by the Ministry itself, offers special transmissions for older people named "Senioren-Académie um 100.7" (Seniors Academy on 100.7). Within the building of a European information society, Government has lauched the *e*Luxembourg programme, and the Ministry of Family Affairs, Social Solidarity and Youth, concerned by the fact that the older population shows to be not so familiar with electronic information technology, pays for the equipment of so called "CyberCafés" in the Clubs Senior and in other active sections of major NGOs operating in the aging field. In addition, the Ministry is running through one of its departments a website for seniors - www.luxsenior.lu – a resource, on which relevant information on old age related services and institutions, as well as schedules and programmes of NGOs' events, including detailed information on the dependency insurance can be consulted. Furthermore, the Ministry has set up two different hot-line systems, especially focused on older peoples' subjects and issues. These are (a) the "service d'appel-assistance senior" also named "Télé-Alarme", a permanently served hot-line for emergency cases and support referring to all kind of health and social issues, operated with special pre-installed technical equipment and run by the foundation "Hëllef Doheem", and (b) the "Senioren-Telefon" (phone for seniors), served during the week days by employees of the Ministry, with most of the requests being related to information seeking on institutions and service provisions for older people and the dependency insurance. Finally, the Ministry offers through specialised collaborators "case-management", with cases related mostly to issues like urgent institutional placement, with the objective to work out preliminary as well as definitive solutions on a person-centred basis. In general, these systems of support aim at informing and supporting older people and / or the

family network, and insofar are related in a direct or indirect way in the systems of support for family caregivers.

National policy frame: The national policy framework for older people as published in the Ministry's of Family Affairs, Social Solidarity, and Youth activity report (2003) lists 11 general considerations. These 11 considerations are a mixture of mission statements, goals, specific measures aiming at different goals and some selected basic data. In the following the 11 considerations are summarised according to their listing in the document:

(1) It is stated that older people *do not represent a homogeneous group*, and that policy actions are focused with high priority to people, who are in a dependent situation, as well as to the members of their socio-familial environment. Older people are defined here as those with an age range of 55 / 60 to over 100 years.

(2) Comparing Luxembourg to the other members of the European Union, senior citizens are retiring rather early from professional activities, with a relatively high income. Even at the age of 80, 4 out of 5 persons, i.e. 80 %, show a solid functional status allowing them to live in an autonomous way.

(3) Politics should not only be planned *for* older people, but it is seen as indispensable to conceive future actions together *with* older people by a close cooperation between the Ministries in charge with the Higher Council for Older People.

(4) Politics in favour for the third and fourth age often limited its focus on the issue of beds needed for the long stay in old people's homes and / or nursing homes. In April 2002 an overall of 4,328 beds were on offer in 35 integrated centres for older people and 14 nursing homes. With a total population of 63,140 of those 65 years and over, this capacity corresponds to 6.8 %. Compared to the 4 % the neighbouring countries are aiming at, this figure can be evaluated as quite high. Considering the fact that within running projects the number of beds in such facilities will be extended within the next couple of years by 1,350 units, the offer of assistance and support within institutionalised settings might be proportionally one of the largest within the EU countries. With these additional offers in long-term care a first adaptation to the growing numbers in the older segments of the population structure has been achieved. Additionally, these institutionalised structures and the service provisions within have been progressively diversified during the last years, which will allow a better fit to the needs and specific aspirations of different user categories.

(5) It is acknowledged that the institutional placement can only be seen as an "ultima ratio" solution, as the vast majority of affected persons prefer to stay as long as possible in their own homes. Responsible public officers as well as service manager invest considerable means to develop a system of support at home: support for care, technical adaptations, home delivered meals, assistance on call, specialised day centres, "holiday" placement, geriatric rehabilitation and gerontological re-validation, advise and training for informal

care givers, a non-paid leave for care assistance for employed family members, benefits for informal care givers (family care) on the basis of the dependency insurance.

(6) With the introduction of the dependency insurance on January 1st 1999, and the complementary payment through the "Fonds National de la Solidarité" (National Solidarity Fund) in cases the personal income of the dependent person does not meet the required level, managers of nursing homes are assured a secure income in order to pay for highly qualified staff. A quality management system is being developed within a consortium of service providers, representatives of government, and national, as well as international experts in order to evaluate the quality within these structures. A central place will be given to the continuous training for staff, the documentation of care services and regular internal as well as external site evaluations.

(7) Dependency is not seen as a fatal state, only being able to respond to it with a growing intensity of care assistance. Moreover, appropriate therapeutic approaches, such as geriatric re-education and gerontological re-validation may result in benefits to dependent persons, thus making some sorts of dependency reversible. Even in cases where a return to an independent functioning is out of sight, such measures might contribute to the stabilisation of the person's dependency level.

(8) Dementias have a reported national prevalence of 2 out of 10 (20 %) for the age group 80 to 90 years and for those over 90 years the prevalence goes up to 3 out of 10 (30 %). Close to half of the senior citizens admitted to structures for long-term care, and taking benefit of the dependency insurance, are suffering from psycho-geriatric disorders. As actually, there are neither preventive nor therapeutic interventions available, concepts have been developed to support these persons with more dignity, attempting to have stabilising effects on the individual's resources, to improve communication with them, and to better handle their fears and agitations. As a matter of effect, it is seen as indispensable to train staff in the required competencies.

(9) The assistance of terminally ill persons is acknowledged to be a major social challenge. Considering the fact that today death is correlated prominently with a higher age, and considering the nowadays diversity in family cultures, the ministry in charge does not respond with a single mainstream strategy to this challenge. Therefore a highly diversified mixture of out-of-hospital measures have been promoted and implemented: support and palliative care at home, hospices, leave for employed family care givers without salary, training in palliative care for various care givers - professionals, informal, as well as family carers and volunteers.

(10) Basic training, as well as continuous training in gerontology and geriatrics takes a central position. The lack of competent and motivated staff has become of prime interest to many service managers in the neighbouring countries. The ministry in charge has responded to this challenge with set of

initiatives: training for specific functions in socio-family support; implementation of a master programme in gerontology at the University of Luxembourg; continuous training programmes organised by various services or associations, such as: the RBS socio-family service; the Luxembourgish Alzheimer Association (ALA) or OMEGA 90 (Association for Training in Palliative Care).

(11) The ministry in charge cooperates closely with representative organisations working in the field of seniors and the gerontology arena in Luxembourg in order to develop its initiatives and to respond to its role as the national coordinator of the aging services. Major partners are:

- ALA (Association luxembourgeoise Alzheimer; Luxembourg Alzheimer Association);
- ALGG (Association luxembourgeoise de Gérontologie / Gériatrie; Luxembourg Gerontology / Geriatric Association);
- Conseil Supérieur des Personnes Agées (High Council for Older People);
- COPAS (Confédération luxembourgeoise des Prestataires et Ententes dans le Domaine de Prévention, d'Aide et de Soins aux Personnes Dépendantes; Luxembourg Confederation of Service Providers and Associations of Prevention, Assistance and Care for Dependent People);
- EGIPA (Entente des Gestionnaires des Institutions pour Personnes Agées; Association of mamagers of old peoples' home institutions);
- OMEGA asbl (service for palliative care);
- Service socio-familial RSB (RSB socio-family service).

"Centres Intégrés pour Personnes Agées" (Integrated Centres for Older People): Besides the first substantial efforts in promoting and supporting family care, in addition to the traditional long-term institutions with separated institutions for homes and nursing facilities, so called "Centres Intégrés pour Personnes Agées" (Integrated Centres for Older People) have been newly set up or existing institutional settings have been transformed to this new type. With social inclusion acting as the main principle within this changeover process the national policies in favour of dependent older people and their families were mainly re-defined. Accordingly, social inclusion aims here at:

- Decentralisation of service provisions through the development of regional service provisions;
- Developing programs re-valuing older people in the gerontology services by training front line staff in new person-centred assistance concepts;
- Promoting programs preventing dependency – through the three level model of prevention;
- Promoting the right of ageing on place as long as possible – developing a high density in the respite care system;

- Calling upon the responsibility of families and between family members – by incentives for caring family members, and strengthening family values.

Table 9 summarizes existing service structures in Luxembourg in 2004.

Table 9: Overview of existing service structures

Type of structure	Number
Integrated centres for older people	34
Nursing facilities	15
Assisted accommodation settings for older people	16
Psycho-geriatric centres	22
Regional centres for activities and guidance for older people	12
Support at home	6
Care at home	7
Food-delivery at home (repas sur roues)	33
External assistance hot-line	1
Senior activity programme	4

Financial commitment in 2002 for new buildings or adaptations to existing buildings: The ministry's financial commitment for infrastructural investments in the socio-familial sector for older people totalled in the year 2002 to € 34,008,809.44. This amount comprises expenditures related to new constructions, transformations and renovations for integrated centres for older people, nursing homes, day centres, as well as payment of first equipment of these buildings.

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for carers?

Dependency is defined in the law underlying the dependency insurance as a living condition, where a person – due to a physical, mental or psychiatric, illness or deficiency of a similar nature- regularly (at least 3.5 hours per week) needs a considerable amount of assistance from a third party in order to carry out basic daily tasks. The basic acts of living comprise the bodily hygiene, nourishment and alimentation, and mobility, and as already mentioned above there is no qualifying period for the services of dependency insurance, except for those persons, who contracted an optional insurance, and who are entitled to benefits only after a one-year qualifying period. The need for aid and care has to be significant and on a regular basis, and is evaluated by the "Cellule d'évaluation et d'orientation" (CEO), being established under the lead of the Ministry of Social Security. Personnel of this centre visit persons at home and in nursing homes to estimate the need for care. The final decision on the establishment and amount of services based on the advice provided by the

CEO is taken by the “Union of Sickness Funds” (“Union des Caisses de Maladie”).

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

As has been described above this is the former “Ministry of Family Affairs, Social Solidarity, and of Youth (“Ministère de la Famille, de la Solidarité Sociale et de la Jeunesse), since July 2004 being the Ministry of Family Affairs and Integration (Ministère de la Famille et de l’Intégration”), and the Ministry of Social Security (Ministère de la Securité Sociale), who is also in charge for the dependency insurance.

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

No recent case law on rights and obligations of family carers was reported to the authors during their research, but amendments to the law on dependency insurance are in discussion (personal communication from the Ministry of Family Affairs).

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)?

Working and employed people are entitled to their retirement (pension benefit) in general at age 60 for women and for men an age 65. People with chronic diseases and invalidity are entitled to earlier retirement. Retirement at age 68 is possible though it will be the exception.

2.2 Currently existing national policies

2.2.1 Family carers

Services provided by the dependency insurance; see also above.

2.2.2 Disabled and / or dependent older people in need of care / help?

According to the statistics provided by the Ministry of Social Security (2003) dementias besides problems associated with locomotion (i.e., skeletal muscles, sinews and joints) are the most frequent causes of dependency. Together, these two classes of troubles do cover 46 % of all cases between 70-80 years, 66 % within the age group of 80-89 years, and 73 % cases above 90 years of age. Mental and behavioural troubles associated with dementia constitute 24.9 % of the dependency causes within the group between 70-79 years, 33.7 % between 80 and 89 years, and 38.2 % in the group of persons

older than 90 years. Special emphasis will be given to the situation of older people with intellectual disability in the following.

Older people with intellectual disability. With respect to intellectual disability (developmental disabilities, mental retardation) Luxembourg is confronted by a growing life expectancy of people with intellectual disability, a fact to be observed throughout the world (Herr & Weber, 1999). In addition, it can be observed throughout the world and also in Luxembourg that families are the major providers of care for adults with developmental disabilities. Taking into account the growing life expectancy of these individuals many of these adults are either living with elderly family members or are outliving their parents. International data show that over a quarter of family caregivers are estimated to be over the age of 60 and another one third is between 41 and 59 years of age (Heller, 2004). The demands placed on the services for people with development disabilities often far surpass the availability.

In general, Luxembourg shows a highly developed and diversified system of supports for children, adolescents and young adults with disabilities, including people with developmental disabilities. In 1993 Government adopted a program in favour of handicapped people having as objectives social integration and access to autonomy to be achieved through the systematic application of three major principles: a) differentiated approach for the development of service structures, b) normalisation, and c) solidarity. This program resulted in a national action plan in favour of people with disabilities, focusing mainly on issues of accessibility, regular income, wages for people with disabilities working in sheltered work shops and the establishment for a better coordination of the supports for people with disabilities and their families ("one stop shop"). Up to now, a special policy document on issues related on aging and disabilities, especially intellectual disability and the so-called "grands handicapés à vie" (severe life-long handicap) has not been developed. However, older people with developmental disabilities are affected directly by the so-called act "ASFT" of 1998 regulating the relation between the State (Government) and the service providers operating in the social-therapy field. The regulation defines standard for quality assurance for services in favour of people with disabilities in general. The services on offer include, accommodation (institutional, semi-institutional or family based), day centres (for people with severe and multiple disabilities), training (independent living, professional), work (training, therapy oriented), employment for handicapped persons, communication (information activities, animations, social integration), early intervention (special education for young children and support for their families), and support and assistance at home (support within the family's home, material and psychological support, aiming at promoting the family's home as the home the person with disability). In 2002 an over all number of 581 persons (out of which 305 women) with disabilities lived in 33 accommodation settings of various service providers operating in the disability field and supported by the Ministry. The majority in this population is characterised by mental retardation of various levels (mild to severe), with or

without physical disabilities physical, a smaller part by physical disabilities and an even smaller group are people with autism. This population covers all the ages, from the youngest ages, 0 to 9 years up to the age group of 80 and plus. Table 10 offers the figures related to the distribution according to the age groups, showing that the age group between 10 and 19 is not represented, meaning that these people are living within their families, with the age group of 40 to 59 being the largest one with 42 % and those aged 60 to 79 representing 12.3 % of the population living in accommodation service provisions.

Table 10: People with developmental disabilities living in supported accommodation service according age groups

Age group	N	%
0-9	39	6.7
20-39	225	38.7
40-59	244	42.0
60-79	71	12.3
≥80	2	0.3
Total	581	100.0

The APEMH – a parents' founded association for children with mental retardation- being one of the major service providers in this field, has set up a few housing facilities especially for older people with disabilities with placements in general for 8 people, the so called "Foyer Senior" (senior homes). Such accommodation facilities for older people with disabilities offer so-called communication services. These services aim especially at preventing the users from social exclusion, offering old age sensitive animation and activity programs. In 2004 the first "Centre Intégré pour Personnes Handicapées Agées" (CIPHA), (Integrated Centre for Older People with Disabilities) has been opened, with a final capacity for 56 senior residents, managed by the "Fondation Kraizbierg".

However, many parents continue to support their older children and might be in need of supports themselves as they are getting frailer and frailer. In the field of developmental disabilities parents themselves are, or act like the "Hëllef Doheem" service for their children with disabilities without enjoying a formal system of support. According to findings from interviews with service providers from the field of developmental disabilities, some of them might offer in a more or less informal way respite care to older parents supporting their older children with intellectual disabilities at home. Service providers in general agree that the "dependency insurance" shows in many cases not to be the appropriate tool for assisting older people with intellectual disability living at home or in a semi-independent setting. Issues still waiting to be addressed as viewed by representatives of service providers are: system of support for parents living with older children with intellectual disability, research on demographic changes in this special section of the national older population, a

model-plan for housing and accommodation for the older people with intellectual disabilities, and a national concept and action plan for older people with life-long disabilities in general.

Taking into account that a significant number of age 40 and over still living with their aging parents and that many of these people might outlive their parents and will continue to need some sort of assistance in their daily living, it can be expected that a significant increase in placements for older people with developmental disabilities will be of need within the next two decades. This statement can be supported by two findings: First, a reported increase of up to 100 % in the 60+ population with intellectual disability up to 2030 from international research (Weber, 2004) and second, a finding from the Ministry's 2002 activity report, describing a population of a sheltered work shop, which opened in 2002 in the rural western part of Luxembourg, as an adult one, with most of them living at home with their parents who are themselves between 50 and 80 years old. The conclusion to be found in the report is: What will happen to the users the very day their parents will no more be able to support their children?

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)

Persons being in charge for family members in need of care are supported in Luxembourg by a contribution to their pension fund on the basis of a *monthly social minimum wage* fixed for a non-qualified worker. Besides this, family carers do not obtain a *direct* financial gratification, since the nursing allowance goes directly to the dependant persons or his or her tutor. Besides the services provided by the help networks or the residential care to the amount of hours assessed by the CEO and granted by the *Union of Sickness Funds*, each beneficiary receives an additional amount of € 23.85 per hour of care, and he or she can dispose of this money for gratification for the informal caregiver. Furthermore, the beneficiary receives each year the double amount of his or her nursing allowance, which should be used to finance a *stand-in person for three weeks* during a year and give the informal carer time for recreation. Additionally, *temporary stays in a nursing home* are directly financed by the dependency insurance.

2.3 Are there local or regional policies or different legal frameworks for carers and dependent older people?

No, considering the size of Luxembourg.

2.4 Are there differences between local authority areas in policy (and thus provision) for family carers and / or older people?

No, considering the size of Luxembourg.

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)			X	X				
Counselling and Advice (e.g. in filling in forms for help)			X	X	X			
Self-help support groups	X							
„Granny-sitting"		X					X[1]	
Practical training in caring, protecting their own physical and mental health, relaxation etc.			X	X				
Weekend breaks			X	X				
Respite care services			X	X				
Monetary transfers			X	X				
Management of crises			X	X				
Integrated planning of care for elderly and families (in hospital or at home)			X	X				
Special services for family carers of different ethnic groups		X						
Other							X[1]	

3.1 Examples

3.1.1 Good practice

Both help networks "Hëllef Doheem" and "Help", which came into being since the installation of dependency insurance, may be named here. Both have the legal status of foundations and do directly cooperate with the Union of Sickness Funds. During the five years of their existence both organisations have progressively elaborated their profile of services and aids as well as their professional structure.

[1] A total of 23 associations and foundations across the country provide services such as minor repairs and aids as well as visits in residential homes on a volunteer basis.

3.1.2 Innovative practices

- Training courses are provided by both networks offering information as well as training in caring skills;
- Training in palliative care is offered by the association OMEGA90 preparing also for the loss of a loved one;
- Psychological counselling;
- Telephone hotlines;
- Various web-sites of both foundations as well as the Ministry of Family Affairs offering information on service offers.
- See the annexe for a description of the networks:
  - Hëllef Doheem (Help at Home)
  - Help

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

4.1.1 Health services

4.1.1.1 Primary health care

The two Help-networks provide all services paid for by the dependency insurance as well as additional services financed by public funding. Care services include support with daily activities and routines (i.e., hygiene, mobility, nutrition), domestic tasks (i.e., washing, shopping, cleaning), individual support activities as well as counselling; aids at home covered by the dependency insurance comprise injections, infusions, taking blood samples, bandage and bonds, surveillance and posing of tubes and catheters; control of diabetes. Additional services are object to negotiation with the dependency assurance and / or are financed by donations.

Physiotherapy, chiropody, as well as home lab tests are available, but have to be paid for separately.

4.1.1.2 Acute hospital and Tertiary care

In January 2004 an overall of 4,562 beds were on offer in 34 integrated centres for older people and 15 homes specialised on care (Ministry of Family Affairs, 2004). With a total population of 63,656 of those 65 years and over, this capacity corresponds to 7.17 %. Compared to the 4 % the neighbouring countries are aiming at, this figure can be evaluated as quite high. Considering the fact that within running projects the number of beds in such facilities will be extended within the next couple of years by 1,350 units, the offer of assistance and support within institutionalised settings might be proportionally one of the largest within the EU countries. With these additional offers in long-time care a first adaptation to the growing numbers in the older segments of the population structure has been achieved. Additionally, these institutionalised structures and the service provisions within have been progressively diversified during the last years, which will allow a better fit to the needs and specific aspirations of different user categories.

There are 23 “Centres psycho-gériatriques” with a capacity of more than 400 beds, which are offered by several foundations and one religious. The network “Hëllef Doheem” provides seven centres, followed by the Luxembourg Alzheimer Association (Association Luxembourg Alzheimer asbl) being in charge of six further centres, a Franciscan order (“Congregation des Franciscaines de la Miséricordes asbl”) as well as the network HELP hold another four centres. A centre for recreation, orientation, validation and

reactivation" ("Centre de recreation, d'orientation, de validation et de reactivation") leads by the Luxembourg Red Cross offers another 105 beds; the capacity concerning geriatric facilities can thus be estimated over 500 beds.

4.1.1.3 Are there long-term hospital care facilities (includes public and private clinics)?

A total of 15 nursing homes ("Maison des soins") with long-term facilities exist, providing a total of 1,262 beds plus 35 beds for short-stay. Foundations, associations and the abovementioned Franciscan order direct all of these homes.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

With summer 2003 the foundation and installation of a hospice was decided by the Ministry of Family Affairs, which will be located in the city of Luxembourg. A law on the right for palliative care has been proposed during 2003 and will be launched during the current legislative period, so every hospital in Luxembourg will install a palliative care unit. Concerning professional training, the Ministry of Health has started training in palliative medicine for medical doctors in 2003, the foundation OMEGA90 offers courses in palliative care for nurses and other health professionals as well as volunteer persons since more than ten years, and there are plans to establish courses on palliative care at the University of Luxembourg. Additionally, both help networks elaborate their structure on palliative care at home and are in negotiation with the dependency assurance on this.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

The first task of family carer starts with the demand of an evaluation of the necessary aids; after this procedure has been accomplished help and care are provided to the degree assessed as necessary by the CEO (see 4.1.2.1.2). There are no statistics available on *when* and under what conditions family members will start to use the services provided by the help networks, and this certainly has to be studied in the future. Concerning the common activities of informal and formal helpers, data are missing as well, but cooperation is certainly desired and represents a necessity, especially if services are provided to a restricted amount.

Concerning social expectations and norms, one may state that in Luxembourg as well as in most other Western-European countries especially daughters are considered to be in charge of the elderly, which is also reflected by the relation of carer's generation and dependant person. Besides this general assumption, data from the European Study on Adult Well-being can be used here as well to get a further insight into the *availability of helpers*. Respondents had been asked here *"Is there someone who would take care of you if you were sick or*

disabled?" and the relative and absolute distribution of answers to this question is displayed in the following table. A total of 1,976 persons answered this question, 169 did not respond.

Table 11: "Is there someone who would take care of you if you were sick or disabled?"

Response	50-59 years	60-69 years	70-79 years	80-90 years	Total
No one willing and / or able to help	15 2.0 %	38 4.6 %	20 5.2 %	8 4.3 %	81 3.8 %
Yes	664 89.5 %	722 87.0 %	337 87.1 %	172 92.5 %	1,895 88.3 %
No response	63 8.5 %	70 8.4 %	30 7.8 %	6 3.2 %	169 7.9 %
Total	742 100.0 %	830 100.0 %	387 100.0 %	186 100.0 %	2,145 100.0 %

The analysis of the responses shows that the overwhelming majority of respondents in all four age groups confirmed to have a person who would take care in case of sickness or disability. On the level of the total sample a proportion of 88.3 % gives such a positive answer; the proportions range between 87 % in the group of 60-69 years and 92.5 % in the group of the oldest persons. The proportion of persons giving no response was highest in the two youngest age groups and lowest in the oldest age group averaging to 7.9 % in the total sample. A proportion of 3.8 % of the total sample finally stated that no one would be willing or able to help, varying between a proportion of 2 % in the youngest age group and 5.2 % in the age group of 70-79 years.

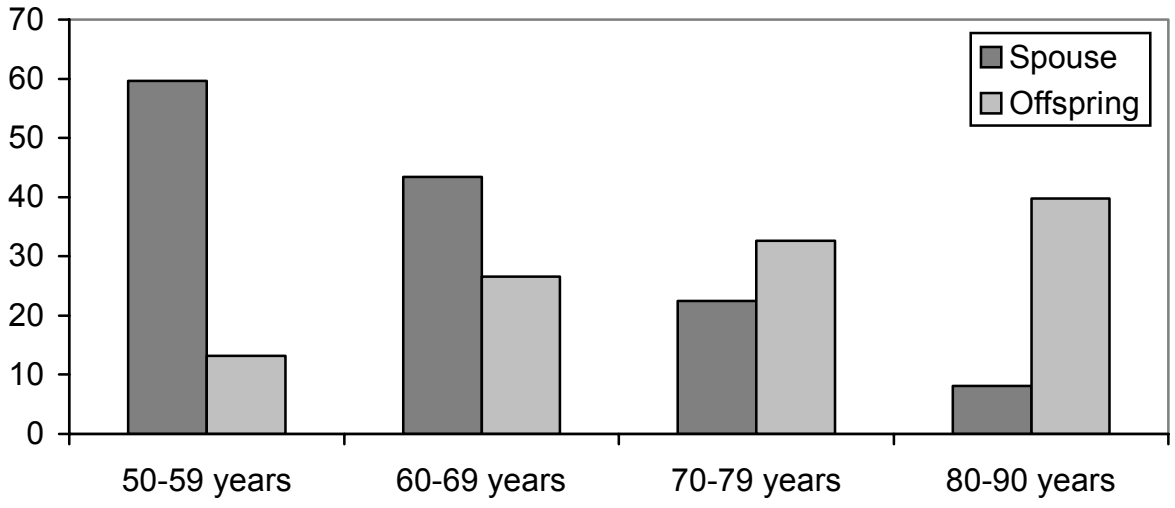
Beside other specification, respondents were also asked to specify the potential person being in charge and an extract of the responses obtained here is summarized in the following table.

Table 12: Who is this person, who will take care of you if you were sick or disabled?

Persons	50-59 years	60-69 years	70-79 years	80-90 years	Total
Spouse	442 59.6 %	360 43.4 %	87 22.5 %	15 8.1 %	904 42.1 %
Sibling	26 3.5 %	29 3.5 %	15 3.9 %	5 2.7 %	75 3.5 %
Offspring	98 13.2 %	221 26.6 %	126 32.6 %	74 39.8 %	519 24.2 %
Others	73 9.8	91 11.0	85 21.9	71 38.1	320 14.9 %
No response	103 13.9 %	129 15.5 %	74 19.1 %	21 11.3 %	327 15.2 %
Total	742 100.0 %	830 100.0 %	387 100.0 %	186 100.0 %	2,145 100.0 %

The table shows that 42.1 % of the total sample named the *spouse* as being responsible for care in case of sickness and dependency, followed by the *offspring* on the second position with a relative frequency of 24.2 %. Probably due to mortality rates for men, these trends turned around when considering the age groups: The responsibility of the spouse decreased from 60 % in the age group between 50-59 years to a proportion of 8.1 % in the oldest group between 80-90 years; on the other side the attributed responsibility for the offspring increased from a relative frequency of 13.2 % in the group of 50-59 years to a proportion of 32.6 % and 40 % in the age groups between 70-79 years and 80-90 years respectively.

Figure 3: Attributed responsibility for informal care in four age groups



4.1.2 Social services

4.1.2.1 Residential care (long-term, respite)

4.1.2.1.1 Basic data on % of >65s in residential care by age group and type of residential care (sheltered housing, residential homes)

The Ministry of Family Affairs (2004) has recently published statistics on the use of 34 Integrated Centres for the Elderly as well as 15 nursing homes: The total of these 49 institutions provides 4,562 beds, being used by a total of 4,302 seniors on January 1st 2004, which represents an utilisation ratio of 94.3 %.

Table 13 summarizes the number of persons in the age group above 50 years in these institutions. Here it gets evident that starting with the age of 70 years the proportion of persons in integrated centres as well as nursing homes increases dramatically and is most pronounced for the age group over 80 years. Approximately 93 % of all residents belong to the age groups between 70-79 years (20.5 %), 80-89 (45.4 %) or to the group of seniors over 90 years (25.2 %). With reference to the total population in these age groups in Luxembourg, this results in proportions of 2.8 % of persons between 70-79 years, 16.8 % of persons between 80-89 years, and 55 % of persons over 90 years of age being in integrated centres or nursing homes.

Table 13: Number of persons in 34 "Integrated centres for the elderly" and 15 nursing homes by age group (situation January 1st 2004)

Age group	Number of persons	% Of persons in 49 institutions	Total population	% Of total population
50-59	68	1.58	53,910	0.13
60-69	226	5.25	39,491	0.57
70-79	882	20.50	31,004	2.84
80-89	2,040	47.42	12,310	16.82
≥90	1,086	25.24	1,987	54.66
Total	4,302	100		

4.1.2.1.2 Criteria for admission (degree of dependency, income)

Living at home as long as possible characterizes the policy approach in the field of ageing in Luxembourg and this is realized by the dependency insurance. Currently the obvious criterion for admission to a residential or nursing home may therefore be best described by the fact, that the respective person, the informal caregiver as well as the help networks are no longer able to secure a comparatively independent living at home. This is the case if the

amount of necessary help exceeds the maximum limits of services and aids foreseen by the dependency insurance.

4.1.2.1.3 Public / private / NGO status

As already pointed out above, the vast majority of the institutional structures and the services continue either to be *publicly managed* or they are run by *non-for profit-organisations* as institutions with a public utility and are thus indirectly publicly controlled, with the government or the municipalities supporting the annual running costs of these institutions. The Ministry of Family Affairs has signed contracts with different services for the elderly (summarized in Table 12 above), being it NGOs, foundations or religious orders.

4.1.2.1.4 Does residential care involve carers or work with carers?

This depends on the special institution under consideration, and there are no statistics available on this.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

4.1.2.2.1 Home-help

The help networks provide these services, besides this up to 23 foundations and associations exist, which do offer help at home on a volunteer basis be it minor repairs, services such as shopping as well as visiting of persons in residential homes.

4.1.2.2.2 Personal care

Provided by the help networks according to the amount estimated by the CEO.

4.1.2.2.3 Meals service

A total of 27 services providing meals on wheels are distributed across the country and are provided by communities or cities as well as the Red Cross.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Help networks provide these, as well as the abovementioned volunteer associations.

4.1.2.2.5 Community Care Centres

The so-called Senior Clubs (Club Sénior - Centres régionaux d'animation et de guidance") aim at fostering the autonomy and independence of elderly people living at home. Programmes provided by the 13 regional clubs are offered for persons above 50 years and comprise the preparation of the exit from work

life, various leisure time (e.g., sports, organized journeys) and cultural activities. Participation in diverse programs is free and can be used on a regular as well as an occasional basis. A special emphasis in the activities of the clubs is giving to *intergenerational* relations and activities offering programs, which can be used not only by the elderly and younger generations in common.

4.1.2.2.6 Day care ("protective" care)

The network "Hëllef Doheem" has installed seven psycho-geriatric day-care centres and further centres are in development.

4.1.2.3 Other social care services

Home adaptations are provided by dependency insurance if the need has been assessed. The help networks provide training of informal carers as well.

4.2 Quality of formal care services and its impact on family care-givers: systems of evaluation and supervision, implementation and modeling of both home and and other support care services

4.2.1 Who manages and supervises home care services?

The management of home care is task of the help networks, which are so to say supervised by agreements signed with the Union of Sickness Funds.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls

A quality control of the services is realized on the one hand by the abovementioned agreements, which do specify the range, amount and costs of services and aids. Besides this, the administration of both networks is aware of the necessity of quality control, and currently the network "Hëllef Doheem" is being evaluated by a foreign evaluation institute.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

Yes, if the carers do not already have a qualification as a nurse or assistant nurse, carers can obtain a professional training for assistant nurse. For special domains such as palliative care courses accredited by the Ministry of Health are offered.

4.2.4 Is training compulsory?

Continuing education is insofar compulsory, since each employer in the social sector has to guarantee 20 hours of advanced training.

4.2.5 Are there problems in the recruitment and retention of care workers?

There seems to be no problem with the recruitment of care workers, because of the relatively high wages in Luxembourg, which are very attractive for foreign carers from France, Belgium, and Germany. The precondition for working in Luxembourg is the accreditation of the professional training by the Ministry of Health. The problem, which arises with foreign workers, is the abovementioned fact, that these do not sufficiently speak Luxembourgish. Furthermore, unfavourable working time associated with ambulatory care (i.e., permanence during the week, night shifts) aggravates the acquisition of qualified personnel.

4.3 Case management and integrated care

As already described above, the "C*ellule d'évaluation et d'orientation"* (CEO) is in charge of the case management within the frame of dependency insurance. The personnel of this centre, which is linked to and directed by the Ministry of Social Security, comprises the following health professionals: 4 psychologists, 3 physiotherapists, 5 occupational therapists, 14 nurses (four of them being specialised in psychiatric care), four medical doctors, 3 social workers, plus administrative employees. This has been the personnel in 1999 when the dependency insurance came into vigour. As a reaction the amount of demands, additional personnel have been taken on since then, which works on a part-time basis.

Five different steps are taken to evaluate dependency:

- a medical questionnaire and examination;
- a questionnaire on the living conditions of the dependent persons (completed in absence of significant others);
- a questionnaire on the state of dependency as it is perceived by the dependant person;
- a questionnaire on the state of dependency as it is perceived by significant others;
- a questionnaire on the state of dependency as it is perceived by the evaluating person from the CEO.

Based on these reports an individual service plan is worked out specifying the amount of time, measures to be taken and goals of the help. The dependent person and his or her significant others are then informed about the decisions,

which have been taken. If a demand is granted, help networks or the residential home, where the dependent person lives, are contacted; the coordinator of the help network then organizes a visit of the dependant person in his or her surroundings, in order to propose modifications of the help plan and discuss its concretisation. A revaluation of dependency is possible after six months, if there are no dramatic changes in the dependency condition of the concerned person.

4.3.1 Are family carers' opinions actively sought by health and social care professionals usually?

There is no systematic information on this issue available; since the exchange with the informal carer represents one of the preconditions of a close collaboration between informal carers and professionals, it certainly has to be realized. Further research is needed here, especially with respect to the exchange that informal carers may have with different health professionals (e.g., nurse, medical doctor etc).

5 The Cost – Benefits of Caring

The GDP for the country: As already reported above GDP per capita with an amount of $ 49,100 in terms of PPS was more than twice the EU25 average in 2003 (Eurostat, 2004). When evaluating this figure, one has to take into account that the GDP per capita in Luxembourg tends to be overestimated, due to the large share of cross-border workers in total employment. While contributing to GDP, they are not taken into consideration as part of the resident population, which is used to calculate GDP per capita.

5.1 What percentage of public spending is given to pensions, social welfare and health?

STATEC (2003) reports a growth in total social welfare spending (+218.9 %), from 1,356.40 million euro in 1985 to 4,325.90 million euro in 2000. Although this difference is quite high, it represents a relative stable share of 20 % of GDP across the years, which was 21 % of GDP in 2000; although this is lower than the EU average of 22.9 %, average spending per capita in Luxembourg is € 8,214 in PPS, which is highest in the EU15, exceeding the level in Denmark, which is in second place, by 13.6 %.

Old age and survivor's benefits represent 42.1 % of the total social benefits. 38.2 % of social benefits are spent for sickness and health care (STATEC, 2003). This represents 5.6 % of GDP according OECD (2003), which reports an average of 8.4 of GDP on health spending in a comparison of 28 countries including the EU-15. A breakdown of social security benefits in Luxembourg is depicted in the following table.

Table 14: Breakdown of social security benefits in % of the total (STATEC, 2003)

Function	1985	1990	1995	2000
Health of which:	40.7	39.4	37.8	38.2
Sickness	23.3	24.0	23.6	23.4
Dependency	–	–	–	3.1
Invalidity	13.6	12.3	11.3	8.7
Occupational accidents and illnesses	3.8	3.1	2.9	3.0
Retirement, survivor's pensions	48.0	47.6	46.6	42.1
Maternity, family allowances	9.1	10.9	13.3	16.9
Unemployment, placement	1.4	0.9	2.2	2.3
Housing, miscellaneous	0.8	1.3	0.1	0.4
Total	100.0	100.0	100.0	100.0

Social protection is financed by general government contributions (47.1 %), employer's social contribution (24.6 %), social contributions paid by the protected person (23.8 %) and other aids (4.5 %; STATEC, 2003).

5.2 How much – private and public – is spent on long term care (LTC)?

As already described above, the vast majority of the institutional structures and the services continue either to be *publicly managed* or they are run by *non-for profit-organisations* as institutions with a public utility and are thus indirectly publicly controlled, with the government or the municipalities supporting the annual running costs of these institutions.

5.3 Are there additional costs associated with using any public health and social services?

Besides the 20 % of self-contribution to the health costs, no compulsory additional costs are in vigour.

5.4 What is the estimated public / private mix in health care?

Private associations or foundations manage the majority of the hospitals. A few public run general hospitals do exist, with the largest one being the "Centre Hospitalier" of the City of Luxembourg. In addition, the State runs specialised hospitals (psychiatric hospital rehabilitation centre, geriatric centre). The same stands for social care, with the majority of service provisions being managed by private associations and foundations, recognized by the State as being of public utility.

5.5 What are the minimum and maximum costs of using residential care, in relation to average wages?

Considering the high average income per capita in Luxembourg, residential care can be afforded by the better part. In cases, where the income does not permit a complete financing the National Fund of Solidarity (Fonds National de la Solidarité, founded in 1959) is in charge to pay a complement to residential care. According to the statistics of this organisation, which works under the tutelage of the Ministry of Family Affairs, € 1.23 millions (in 2002) and of € 975,000 (in 2003) have been paid as a complement to residential care. A total of approximately 700 beneficiaries profited from these complementary payments.

In the case of persons living at home, who are not covered by dependency insurance, i.e. having a need of less than 3.5 hours per week, which do need the services and aids provided by the help networks, a complement could be

demanded at the Ministry of Family Affairs as well. This complement payment is dependant on applicant's income, and is reimbursed according to a tariff provided by the Ministry of Family Affairs. In 2003 a total of 750 applicants used this procedure to pay for services provided by the network "Hëllef Doheem"; services provided here did comprise domestic task (25 %) and basic care giving tasks (75 %).

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or social contributions?

Funding of care for older people is based in Luxembourg on the principle of solidarity. Contributions are covered through taxes on the wages of the labour force and are fixed with 1 % of the gross monthly wage (income).

Relative costs of home and residential care. A comparison between care at home and residential care is rather difficult since two different models are compared here. The cost of residential care per hour does in general not comprise the costs for the building and installation of the respective care institutions, and when it comes to home care transportation costs are naturally higher. The official tariff proposed by the Union of Sickness Funds comprises € 48 per hour concerning home care, and € 35.82 with respect to residential care. This basic amount is weighted by a coefficient, indicating the qualification of the person being in charge. The services of a nursing aid (a*ide soignante*) are weighted for both services with 1; services provided by a nurse are weighted with 1.3; physiotherapists, occupational therapists, as well as psychologists obtain a higher weighting coefficient. Persons without qualification, who are in charge of domestic aids (such as shopping) or leisure activities, obtain a weight of 0.7.

5.7 Funding of family carers

5.7.1 Are family carers given any care benefits? Are these means tested?

	Attendance allowance	Carers´ allowance	Care leave
Restrictions	None	None	3-weeks within a year
Who is paid?	Beneficiary		Beneficiary
Taxable	no		no
Who pays?	Union of Sickness Funds		Union of Sickness Funds
Pension credits	–	yes	–
Levels of payment / month	Dependent on the estimated need for care	Minimum salary of a non-qualified worker / month	Double amount of nursing allowance / per year

5.7.2 Is there any information on the take up of benefits or services?

Family carers get a contribution to their pension fund on the basis of a monthly social minimum wage fixed for a non-qualified worker.

5.7.3 Are there tax benefits and allowances for family carers?

No.

5.7.4 Does inheritance or transfer of property play a role in care giving situation? How?

The services of the dependency insurance are independent of revenues.

5.7.5 Carers' or Users' contribution to elderly care costs[2]

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner		X				
Specialist doctor		X				
Psychologist			X			
Acute Hospital		X				
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)		X				
Day hospital		X				
Home care for terminal patients	X					
Rehabilitation at home		X				
Nursing care at home (Day / Night)		X				
Laboratory tests or other diagnostic tests at home		X				
Telemedicine for monitoring[1]						
Other, specify						

[2] Information concerning carers or users contribution to elderly care costs have been provided by M. Marco Hoffmann, his help is highly appreciated.

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home		X				
Temporary admission into residential care / old people's home in order to relieve the family carer		X				X
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)		X				
Laundry service		X				
Special transport services		X				
Hairdresser at home			X			
Meals at home			X			
Chiropodist / Podologist			X			
Telerescue / Tele-alarm (connection with the central first-aid station)			X			
Care aids		X				X
Home modifications		X				X
Company for the elderly		X				X
Social worker	X					
Day care (public or private) in community center or old people's home						X
Night care (public or private) at home or old people's home						
Private cohabitant assistant („paid carer")						X
Daily private home care for hygiene and personal care						X
Social home care for help and cleaning services / "Home help"						X
Social home care for hygiene and personal care						X
Telephone service offered by associations for the elderly (friend-phone, etc.)			X			
Counselling and advice services for the elderly						X
Social recreational centre		X				
Other, specify						

c. Special services for family carers	General access:			Access based on:		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Means-tested: Partly reimbursed	Means-tested: wholly reimbursed	Based on severity
Training courses on caring	X					
Telephone service offered by associations for family members	X					
Internet Services			X			
Support or self-help groups for family members[2]						
Counselling services for family carers[3]	X		X			X
Regular relief home service (supervision of the elderly for a few hours a day during the week)[3]	X		X			X
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)			X			
Assessment of the needs	X					
Monetary transfers						
Management of crises	X					
Integrated planning of care for the elderly and families at home or in hospital	X					
Services for family carers of different ethnic groups	X					
Other, specify						

[1] Not available.
[2] Does not exist up till now.
[3] Depending on the severity, counselling or a regular relief home service will be free at point of use; the respective services have to be privately paid if there is no positive opinion of the severity.

6 Current trends and future perspectives

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

As depicted in point 2 policy makers in Luxembourg have recognised the challenges associated with the ageing of the population and have taken relevant measures to deal with these. One may cite here the capacity of hospital beds, especially the long-term facilities, which ranges above the European mean, and certainly the introduction and implementation of the dependency insurance. The model underlying this insurance relies on a close cooperation between the national government and organisations of a public utility providing services. This allows for a clear-cut definition of services and aids as well as an establishment of quality criteria to be realized by the providers of services. Moreover, this direct link inhibits the development of a *care market* in the sense of private care providers working profit-oriented and in concurrence to the established networks, since the Union of Sickness Funds discounts services only with the help networks. The latter do cooperate and try to complement their services.

Within the framework of social inclusion characterizing the policy approach towards the elderly in Luxembourg, several challenges for the future exist nevertheless on different levels. Quality control and scientific evaluation of the help networks with respect to their structure as well as the services provided certainly will be one on these. Concerning the offer of services, further emphasis will certainly have to be put on the elaboration of palliative care at home. On a more global level, the financing of services in the years to come will be an important task for Luxembourg with its specific economic situation. A first warning sign indicating a challenge of the social security system have been the above reported deficits of the Union of Sickness Funds, and new models with respect to private provision for one's old age will certainly have to be discussed in Luxembourg as well.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

Considering the comparatively small period of the dependency insurance's implementation a prognosis on the development is rather difficult. What certainly will be needed in the future is more research to provide detailed information on the situation of family carers (see 6.5).

6.3 What is the role played by carer groups / organisations, "pressure groups"?

There are currently no carer groups or organisations in Luxembourg, which may be interpreted as an indicator of a relative contentment with the help networks. On the other hand, national organisations cited above and among these especially the Alzheimer Society of Luxembourg (ALA), the Luxembourg Confederation of Service Providers and Associations of Prevention, Assistance and Care Field for Dependent People (COPAS), as well as the Association of Managers of Old Peoples' Home Institutions (EGIPA) have a direct link and stay in close contact with the responsible ministries (Ministry of Family Affairs, Ministry of Social Security, Ministry of Health), and elaborations and plans considering the gerontological as well as the geriatric sector are coordinated between the respective groups of interest.

6.4 Are there any tensions between carers' interests and those of older people?

Nothing is known about this, i.e. no reports on tensions.

6.5 State of research and future research needs (neglected issues and innovations)

As stated above, further research on the psychosocial situation of family carers is certainly necessary in Luxembourg; besides casuistics little is known about socio-demographic characteristics, caregiver burden, relations between informal helper and dependant persons including positive as well as negative aspects, and contentment with services as well as further needs and expectations concerning help provided by the networks.

6.6 New technologies – are there developments, which can help in the care of older people and support family carers?

The "Télé-Alarme" as well as the senior telephone as hot lines, providing information about the dependency insurance, residential homes and help networks, represent developments to be cited here, as well as the above mentioned *e*Luxembourg programme and the website luxsenior.lu.

6.7 Comments and recommendations from the authors

Comments and recommendations have been integrated within the reported context of the document.

7 Appendix to the National Background Report for Luxembourg

7.1 Socio-demographic data

7.1.1 Profile of the elderly population-past trends and future projections

7.1.1.1 Life expectancy at birth (male / female) and at age 60 years

Over a period of 30 years, life expectancy at birth has increased by eight years for men and six years for women. Today, it stands at about 75 years for men and some 81 years for women. The clear decline in infant mortality has played a central role in this trend. The number of deaths of infants under one year of age per 1,000 live births has dropped through several levels, and is now around five, which matches the level in many European countries. This drop in mortality can also be observed at more advanced ages. Male life expectancy at 70 years old increased from 9.5 years in 1970 to 12.2 years in 2000. For women, it increased from 11.9 years to 15.5 years.

Table 15: Life expectancy at different ages in Luxembourg

Year	Age 0	Age 50	Age 70	Age 0	Age 50	Age 70
1970	67.3	22.4	9.5	74.5	27.5	11.9
1980	70.0	23.6	9.9	76.7	29.2	13.0
1990	72.6	26.4	11.9	79.1	31.5	14.9
2000	74.7	27.4	12.2	81.1	32.8	15.5

(Source: STATEC, 2004)

7.1.1.2 % of >65 year-olds in total population by 5 or 10 year age groups

Table 16: Population by gender and age group in Luxembourg in 2004

Year	65 and over		80 and over	
	N	% of the total population	N	% of the total population
1970	42,800	12.6	5,900	1.7
1980	49,600	13.6	8,200	2.3
1990	50,800	13.4	11,600	3.1
2000	61,100	14.0	13,000	3.0

7.1.1.3 Marital status of >65 year olds (by gender and age group) 2001

Table 17: Marital status of >65 year olds by gender and age, absolute frequencies

Gender	Age group	Single	Married	Divorced	Widowed	No response	Total
Male	65-69	600	6,965	461	617	44	8,687
	70-74	462	6,040	310	956	22	7,790
	75-79	238	3,120	106	749	35	4,248
	80-84	136	1,436	29	562	15	2,178
	85-89	86	622	14	486	11	1,219
	90-94	32	112	6	205	2	357
	95-99	6	12	1	38	1	58
	≥100	2	0	0	3	0	5
	Total	1,562	18,307	927	3,616	130	24,542
Female	65-69	617	5,965	495	2,737	47	9,861
	70-74	739	4,601	347	3,968	57	9,712
	75-79	705	2,321	181	4,489	50	7,746
	80-84	459	808	87	3,242	46	4,642
	85-89	318	237	41	2,458	49	3,103
	90-94	129	30	23	1,031	25	1,238
	95-99	21	6	1	180	3	211
	≥100	6	0	0	9	0	15
Total		2,994	13,968	1,175	18,114	277	36,528

Table 18: Marital status of >65 year olds by gender and age, relative frequencies

Gender	Age group	Single	Married	Divorced	Widowed	No response	Total
Male	65-69	38.4	38.0	49.7	17.1	33.8	35.4
	70-74	29.6	33.0	33.4	26.4	16.9	31.7
	75-79	15.2	17.0	11.4	20.7	26.9	17.3
	80-84	8.7	7.8	3.1	15.5	11.5	8.9
	85-89	5.5	3.4	1.5	13.4	8.5	5.0
	90-94	2.0	0.6	0.6	5.7	1.5	1.5
	95-99	0.4	0.1	01	1.1	0.8	0.2
	≥100	0.1	0.0	0.0	0.1	0.0	0.0
	Total	6.4	7.6	3.8	14.7	0.5	
Female	65-69	20.6	42.7	42.1	15.1	17.0	27.0
	70-74	24.7	32.9	29.5	21.9	20.6	26.6
	75-79	23.5	16.6	15.4	24.8	18.1	21.2
	80-84	15.3	5.8	7.4	17.9	16.6	12.7
	85-89	10.6	1.7	3.5	13.6	17.7	8.5
	90-94	4.3	02	2	5.7	9.0	3.4
	95-99	0.7	0.0	0.1	1.0	1.1	0.6
	≥100	0.2	0.0	0.0	0.0	0.0	0.0
Total		8.2	38.2	3.2	49.6	0.8	–

7.1.1.4 Living alone and co-residence of the >65 year olds by gender and 5-year age groups

Table 19: Absolute number of persons of the >65 year olds in private households by gender and 5-year age groups

Gender	Age	Persons in private households										Total
		Living alone	2	3	4	5	6	7	8	9	10 and more	
Male	65-69	1,021	5,282	1,426	441	212	152	44	22	8	4	8,612
	70-74	1,085	4,906	1,026	322	176	117	38	18	8	3	7,699
	75-79	674	2,736	407	135	76	77	25	5	5	2	4,142
	80-84	428	1,267	180	67	47	34	16	1	0	2	2,042
	85-89	317	539	93	49	23	19	11	1	1	0	1,053
	90-94	93	103	28	15	17	8	3	0	0	0	267
	95-99	21	15	4	0	1	2	0	0	0	0	43
	≥100	2	0	0	1	0	0	0	0	0	0	3
	Total	3,641	14,848	3,164	1,030	552	409	137	47	22	11	23,861
	%	15.3	62.2	13.3	4.3	2.3	1.7	0.6	0.2	0.1	0.0	100.0
Female	65-69	2,460	5,236	1,169	375	226	155	45	23	13	3	9,705
	70-74	3,354	4,504	805	331	234	143	43	22	10	6	9,452
	75-79	3,577	2,568	503	240	213	107	36	7	2	5	7,258
	80-84	2,111	1,108	306	182	122	64	20	4	1	2	3,920
	85-89	1,240	464	242	128	65	36	10	4	2	0	2,191
	90-94	379	137	102	72	22	14	1	2	1	0	730
	95-99	34	31	27	4	5	4	2	1	0	0	108
	≥100	2	3	0	0	0	0	0	0	0	0	5
	Total	13,157	14,051	3,154	1,332	887	523	157	63	29	16	33,369
	%	39.4	42.1	9.5	4.0	2.7	1.6	0.5	0.2	0.1	0.0	100.0

Table 20: Relative number of persons of the >65 year olds in private households by gender and 5-year age groups

Gender	Age	Persons in private households										Total
		Living alone	2	3	4	5	6	7	8	9	10 and more	
Male	65-69	28.0	35.6	45.1	42.8	38.4	37.2	32.1	46.8	36.4	36.4	36.1
	70-74	29.8	33.0	32.4	31.3	31.9	28.6	27.7	38.3	36.4	27.3	32.3
	75-79	18.5	18.4	12.9	13.1	13.8	18.8	18.2	10.6	22.7	18.2	17.4
	80-84	11.8	8.5	5.7	6.5	8.5	8.3	11.7	2.1	0.0	18.2	8.6
	85-89	8.7	3.6	2.9	4.8	4.2	4.6	8.0	2.1	4.5	0.0	4.4
	90-94	2.6	0.7	0.9	1.5	3.1	2.0	2.2	0.0	0.0	0.0	1.1
	95-99	0.6	0.1	0.1	0.0	0.2	0.5	0.0	0.0	0.0	0.0	0.2
	≥100	0.1	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	1000	100.0
Female	65-69	18.7	37.3	37.1	28.2	25.5	29.6	28.7	36.5	44.8	18.8	29.1
	70-74	25.5	32.1	25.5	24.8	26.4	27.3	27.4	34.9	34.5	37.5	28.3
	75-79	27.2	18.3	15.9	18.0	24.0	20.5	22.9	11.1	6.9	31.3	21.8
	80-84	16.0	7.9	9.7	13.7	13.8	12.2	12.7	6.3	3.4	12.5	11.7
	85-89	9.4	3.3	7.7	9.6	7.3	6.9	6.4	6.3	6.9	0.0	6.6
	90-94	2.9	1.0	3.2	5.4	2.5	2.7	0.6	3.2	3.4	0.0	2.2
	95-99	0.3	0.2	0.9	0.3	0.6	0,8	1.3	16	0.0	0.0	0.3
	≥100	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

7.1.1.5 Urban / rural distribution by age

Luxembourg is divided into 12 administrative districts ("cantons"), which comprise a different number of cities and villages. The total area of the Grand Duchy amounts to 2,586 sq.km which can geographically be subdivided in the Northern region "Oesling" with an area of 828 sq.km and the South "Bon Pays" with an area of 1,758 sq.km respectively. This differentiation can be further elaborated with respect to the following four constituencies:

The South on the French border, comprising the cantons of Capellen and Esch on an area of 441.98 sq.km and a ratio of 374 inhabitants per sq.km.

The Centre with Luxembourg City, Luxembourg-Champagne and the canton of Mersch on an area of 462.36 sq.km with a population density of 318 inhabitants per sq.km.

The East on the German border with the cantons of Echternach, Grevenmacher and Remich on an area of 524.78 sq.km. Population density is quite low at a ratio of 103 inhabitants per sq.km.

The North on the Belgian and German border, finally, comprises five cantons (Clervaux, Diekirch, Redange, Vianden, Wiltz) in an area of 1,157.24 sq.km. This area represents the most sparsely populated region of Luxembourg with a ratio of 60.2 inhabitants per sq.km.

The EU proposes a definition of a district as “rural” according to which an area is characterized as “rural” if less than 100 inhabitants live per 1 sq.km. Thus, the North and the East are described as rural when applying this definition to Luxembourg; whereas the remaining two regions, namely the Centre and the South, represent urban areas. This latter characterization certainly has to be put into perspective compared to other European countries, but it certainly fits for a description of the Luxembourg population. Thus, the North and the East represent the areas with the comparatively highest proportion of agriculture and viticulture; the South and the Centre are described by the exclusive focus of services and industry as economic resources. The combination of the East and North as the rural areas and the Centre and South as the urban areas of Luxembourg results in a proportion of 73 % and 27 % covering the total area.

Table 21: Population density in Luxembourg 2001

Region and its cantons	Density
South	373.5
Canton de Capellen	187.4
Canton d'Esch	559.6
Centre	318.0
Canton de Luxembourg (City and surrounding)	530.6
Canton de Mersch	105.3
North	60.2
Canton de Clervaux	37.8
Canton de Diekirch	112.9
Canton de Redange	51.8
Canton de Vianden	54.0
Canton de Wiltz	44.6
East	103.0
Canton d'Echternach	77.1
Canton de Grevenmacher	104.0
Canton de Remich	127.8

7.1.1.6 Disability rates amongst those >65 years. Estimates of dependency and needs for care

Not available.

7.1.1.7 Income distribution for top and bottom deciles

Not available.

7.1.1.8 % >65 year-olds in different ethnic groups

Table 22: Breakdown of nationalities by age groups, absolute and relative numbers

Nationality	65-69 years	70-74 years	75-79 years	≥80years
Luxembourgish	14,881	14,751	10,274	11,832
	80.2	84.3	85.7	90.8
Belgian	424	405	284	216
	2.3	2.3	2.4	1.7
Dutch	146	151	73	37
	0.8	0.9	0.6	0.3
German	489	386	227	204
	2.6	2.2	1.9	1.6
French	484	411	319	194
	2.6	2.3	2.7	1.5
Italian	1,174	803	495	284
	6.3	4.6	4.1	2.2
Portuguese	493	268	128	87
	2.7	1.5	1.1	0.7
Other	457	327	194	172
	2.5	1.9	1.6	1.3
Total population	18,548	17,502	11,994	13,026

7.1.1.9 % Home ownership (urban / rural areas) by age group

Table 23: Home ownership by age group, absolute and relative numbers

Age group	Own property	Rent-free lodging	Lodger of a non-furni-shed lodging	Lodger of a ready-furni-shed lodging	Subtenant	Other	No response	Total
65-69	15,267	410	2,081	143	69	50	297	18,317
70-74	14,356	457	1,827	112	70	60	269	17,151
75-79	9,241	407	1,360	56	43	99	194	11,400
80-84	4,621	277	758	33	27	116	130	5,962
85-89	2,493	151	366	26	8	119	81	3,244
90-94	747	53	111	4	1	39	42	997
95-99	120	8	10	0	0	7	6	151
≥100	4	1	1	0	0	1	1	8
Total	46,849	1,764	6,514	374	218	491	1,020	57,230
65-69	83.3	2.2	11.4	0.8	0.4	0.3	1.6	100.0
70-74	83.7	2.7	10.7	0.7	0.4	0.3	1.6	100.0
75-79	81.1	3.6	11.9	0.5	0.4	0.9	1.7	100.0
80-84	77.5	4.6	12.7	0.6	0.5	1.9	2.2	100.0
85-89	76.8	4.7	11.3	0.8	0.2	3.7	2.5	100.0
90-94	74.9	5.3	11.1	0.4	0.1	3.9	4.2	100.0
95-99	79.5	5.3	6.6	0.0	0.0	4.6	4.0	100.0
≥100	50.0	12.5	12.5	0.0	0.0	12.5	12.5	100.0
Total	81.9	3.1	11.4	0.7	0.4	0.9	1.8	100.0

7.1.1.10 Housing standards / conditions

Table 24: Indicators of housing standards by age group (percentages)

Housing standard / Conditions	65-69	70-74	75-79	80-84	85-89	90-94	95-99	≥100
Bathroom	98.20	97.70	97.30	96.40	95.70	94.20	95.10	100.00
WC	97.80	97.50	97.40	97.30	96.70	97.10	95.80	100.00
Washing machine	97.30	96.90	95.30	92.60	88.90	85.70	85.90	85.70
Chest freezer	83.70	81.40	76.10	71.10	64.60	63.50	62.60	42.90
Dishwasher	61.90	54.20	47.20	42.40	39.30	40.40	48.90	28.60
Heating								
Central heating	36.20	37.60	40.70	41.00	40.70	42.00	40.30	62.50
Heating	59.40	57.80	55.00	54.20	54.10	52.90	53.20	37.50
Other kind of heating	4.40	4.60	4.20	4.80	5.30	5.10	6.50	0.00
Telephone	98.20	98.20	98.40	98.70	98.40	96.40	96.50	85.70
TV	98.60	98.50	98.20	98.10	97.90	97.80	95.80	100.00

7.2 Examples of good or innovative practices in support services

Two foundations – “Hëllef Doheem” (Help at home) and “HELP” – are in charge of providing aids and services to dependant persons; both are foundations for public utility and represent reunions of several charitable and catholic institutions, being active in the field of care before the implementation of the dependency insurance. Both institutions work in close cooperation with the Ministry of Social Security and the Ministry of Family Affairs. Their history, structure, and profile of services, which are quite similar, will be described in the following.

The foundation “Hëllef Doheem” represents the association of three former foundations:

- “*Aide Familiale Aide Senior*” (Help for Families and Seniors) founded by the Caritas of Luxembourg at the beginning of the 50´s for the support of families in case of illness or absence of the mother, which has enlarged its services for the elderly during the 80´s;
- “*Foyers Seniors*” (Community Centres for Seniors) is a congregation of three community centres for the elderly founded at the late in the 80 which offer several services (meals on wheels, activities, etc.) for the elderly;

- "*Hëllef Doheem Krankefleg*" (Help at home nursing) was founded in the beginning of the 80´s by seven religious congregations in Luxembourg providing care at home.[3]

The aim of the network "Hëllef Doheem" is *to be in charge for everybody* comprising children, adolescents, adults, and elderly in need of support and ambulatory care. In particular, these groups comprise persons with physical diseases, handicapped and / or dependant persons, who have temporary or chronic difficulties, which cannot be compensated for by the family and which put the autonomy and a living at home of the concerned person at risk. Help provided by this institution also addresses persons, who live alone, as a couple or as a family in apartments adapted for elderly. Each service is provided independently of ones philosophical, theological, and religious or ethic beliefs. "Hëllef Doheem" offers its help and care services in each region of the country, and has situated its sites in accordance to a repartition of the country in seven regions (North, East, West, Centre, City of Luxembourg and surroundings, South), which guarantees a high proximity with the persons in need.

The coordination of services represents a central point of the network. A coordinator is foreseen for each client, who is in charge of

- informing the client and his / her family about help care services he or she may profit from,
- the initiation and organization of necessary services, and
- the observation and evaluation of the state of health and / or dependency in order to adjust the services.

Furthermore, the foundation has created an info line, which is at disposition for everybody who is in need of information about the network and its services, the dependency insurance, and the potential measures to be taken to assure a living at home. The personnel structure of the network is multidisciplinary and comprises 25 teams of 7 to 12 professionals across the country under the supervision of a coordinator; each team is composed of nurses, nursing aids, family as well as home helpers; the total of personnel amounts to 1,100 persons. For specific tasks each team can rely on the services of occupational therapists, social assistants, physiotherapists, or psychiatric nurses.

The services of the network comprise the following:

- Each service covered by the dependency insurance, i.e., support with daily activities and routines (i.e., hygiene, mobility, nutrition), domestic tasks

[3] Congrégation des Frères de Charité, Congrégation des Sœurs du Tiers-Ordre Régulier de Notre-Dame du Mont Carmel, Chanoinesses régulières de Saint Augustin de la Congrégation de Notre-Dame, Congrégation des Sœurs de la Doctrine Chrétienne, Congrégation des Franciscaines de la Miséricorde, Congrégation des Sœurs du Pauvre Enfant Jésu, Congrégation des Sœurs Hospitalières de Sainte Elisabeth.

(i.e., washing, shopping, cleaning), individual support activities as well as counselling;

- Each nursing service covered by the national health assurance (i.e., injections, infusions, taking blood samples, bandage and bonds, surveillance and posing of tubes and catheters; control of diabetes);
- Rapid help after a hospital stay, or in case of illness or temporary incapacity due to an accident;
- Providing temporary personnel for assistance and surveillance if a caregiver is in need;
- Various community centres ("foyer de jour") with leisure time activities, contact and communication facilities, as well as food provision;
- 24h Tele-alarm providing instant help in case of acute problems;
- Assistance, counselling and orientation of relatives being in charge for a dependant person;
- Procurement of a temporary stay in a nursing home.

The second charitable organisation "HELP" consists of four organisations and institutions being in charge for domiciliary care and aids. In particular these comprise three residential homes for the elderly and their associated community centres in the north, south, and east of the country (Homes "Syrdall", "Uelzecht", and "Musellheem) as well as the service "Dohéem versuergt" (Help at home) provided by the Luxembourg Red Cross. HELP offers a list of services comparable to the already described services held by "Hëllef Doheem", which are accounted for by the national health insurance and the dependency insurance.

The service approach of "HELP" can be described by its systemic and patient-centred approach realized by a multidisciplinary team. Special emphasis is given to the prevention of dependency comprising both the physical risks as well as psychosocial risks such as solitude and isolation. "Dohéem versuergt", the comparatively largest part of this network, has created since its coordination with "HELP" in 2001 approximately 240 places of work for employees, who are in charge for domiciliary aid and care. The multidisciplinary personnel comprise nurses, nursing helps, family and home helps, physiotherapists, psychologists, and occupational therapists with a clear weight on the first three professional groups. The service offer is structured with respect to 14 help centres across Luxembourg covering – comparable to the network provided by "Hëllef Doheem" – all regions of Luxembourg from the south, east, centre, and north. The resting three institutions provide similar services in close cooperation with hospitals and give work to another 250 persons.

Taken together, the provision of services for care at home seems to be quite sufficient in Luxembourg, since the two networks "Hëllef Doheem" and "Help"

do cover the whole of the country with their offers with a total of approximately 1,600 persons of various qualification and formation being in charge for support in the sector of home care. This may also explain why there are no private care services in Luxembourg. It is also important to note again, that both networks represent organisations for public utility with the legal status of an incorporated society; economic gains that are achieved are reinvested in the elaboration of the service profile.

Challenges, which both organisations will have to face in the years to come, is quality evaluation with respect to structure, services and aids (which is currently realized for “Hëllef Doheem”), the elaboration of services especially with respect to palliative care, as well as a continuous training of their personnel.

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