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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN FRANCE

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The Long-Term Care System for the Elderly in France

ENEPRI Research Report No. 77/June 2010

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1. The long-term care system in France

1.1 Overview of the system

1.1.1 Historical aspects

Development of a public policy in favour of elderly people (1986-1996)

The so-called-Laroque report, published in 1962, is generally considered to be the starting point of policy in favour of the ageing population in France. Nevertheless, it focused more on the economic activities of those of 60 years old and over (in terms of growth and employment) than on the specific issue of dependency (Frinault, 2005a, b).

Dependency really became a public issue in France from 1986 with the *Braun report*, which investigated the specific reasons for the phenomenon and examined what was not working in order to provide an appropriate solution. This report proposed an allowance for retired dependent people; an idea that was later withdrawn because of the problem of financing it (Martin, 2001).

The next solution considered was to promote the trial of initiatives at local level (the 'departmental' level).¹ The state adopted an incentivising attitude to support departmental authorities (*les Conseils généraux*), reducing its own role to that of giving advice (Martin, 1998). This choice was a result of the decentralisation process that began in 1983 and also a result of the crisis of the welfare state (Duran et al., 1996).

Departmental authorities readily accepted this new responsibility easily: Long-Term Care (LTC) represented for them not only the possibility of satisfying increasing demand but also a big opportunity in terms of employment; especially the development of social services (Nogues, 2008a, b).

The recognition of dependency in terms of a social policy (1997-2003)

The first allowance for dependent or frail elderly people (Specific allowance for dependency, *PSD*) was approved in 1997. It was criticised as being inequitable and was replaced by the

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¹ A "department" is a territorial and administrative division of France (96 metropolitan and four overseas departments). Each *departement* is administered by a Department Authority (*Conseil general*).

personalised allowance for autonomy (APA) created on July 20th 2001. The APA is different from the PSD in that it targets three main objectives (Lechevalier, Ullmo, 2001):

- To increase the number of recipients by the removal of the means-tested condition and by the removal of estate tax.
- To raise the number of recipients by giving the possibility of access to medium-dependent persons;
- To define a national financial scale for allowances in order to avoid differences between local governments.

In the summer of 2003, French public authorities suddenly measured the extent to which the LTC system was inefficient. The heat wave of that year caused around 15,000 deaths and shocked public opinion. Most of the victims were elderly people not requiring constant medical care and living alone with no immediate family. This event constituted a turning point in how perceptions changed to make LTC a national priority.

The 'success' of dependency as a new social risk? (2003-2010)

Nowadays, 'dependency' is not yet considered an individualised risk for social insurance², but the French government is studying the question of whether to recognise dependency as a new social risk. The debate is therefore still open about the creation of a risk of dependency taken into account by social insurance or the creation of a compulsory long-term care insurance, mainly because of financing (Assemblée nationale, 2010).

1.1.2 Philosophy of the system

The French LTC system is a mixed system based on Beveridge's and Bismark's models and with family-based characteristics, where families play a central role in financing and assisting LTC (see section 2).

According to opinion surveys, French people are rather more in favour of state intervention for LTC (48% in 2009) than that of families (19%), of pension funds (10%) or of local governments (10%). The French would also prefer to provide financial support for the poorest (76%) though 22% consider that support for LTC should not be means-tested but universal. Finally, regarding the question of how to finance dependency risk, only 50% of the population would agree with a new social tax (David, 2008).

LTC are services for elderly persons who have lost their independence. Indeed, certain *people need help with everyday activities such as eating, dressing, bathing, etc. This loss of independence may be the effect of a disability (physical, mental, intellectual, etc.) or of ageing.*

In France, responses to disability and ageing are different: reaching the age of 60 is still considered to be the distinguishing factor between these two populations.

In this report, long-term care is linked to a situation of loss of independence due to ageing.

1.2 Assessment of needs

Dependency is defined by law. Eligible people are "elderly persons whose health and well-being require follow-up and people who need help to perform activities of daily living (ADL)."

² State social welfare mainly covers four social risks: old age and survival, health, family and accidents at work.

There are several degrees of dependency that are experienced differently by a person depending on the type of ADL affected. The assessment of an individual's need for a type of long-term care has traditionally been based on the measurement of dependency.

The national standardised instrument determining the degree of dependence of old people in France is the **AGGIR scale** (Autonomie Gérontologique - Groupes Iso-Ressources). This scale is based on the degree of difficulty experienced when performing activities of daily living (ADLs)

Elderly people are classified according to six degrees of dependency: *GIR1 (very dependent) to GIR6 (not dependent)* (see appendix).

Only people who belong to Gir1 to Gir4 receive the main allowance: the Personalised Allowance for Autonomy (APA).

Although the AGGIR grid is a relatively comprehensive tool for dependency measurement, it is imperfect. The main criticism is based on the degree of psychological dependence, which is poorly understood at the onset of the disease. If there is no physical impairment, the elderly person is considered to belong to Gir5 or Gir6 and is not entitled to benefits.

1.3 Available LTC services

1.3.1 What services?

The long-term care (LTC) sector is expected to grow due to demographic change. Indeed, there is a threefold stress on LTC provisions (Joel, 2003) due to:

- increasing numbers of elderly people;
- the increased survival of elderly people;
- and the increased survival of frail, disabled elderly people through improved care and health care (Cutler, 2001).

Although it is in fact an area of great interest for social science research, it has not been easy to achieve a full definition of LTC. LTC falls halfway between the health and social sectors because it combines both health and social components.

The challenge is therefore to define the boundary between LTC services in a practical and comprehensive way:

- long-term social care and long-term health care;
- formal and informal care;
- home and institutional based care services.

The complexity in defining LTC is related to the ambiguity of the word 'care' itself. To take the original meaning of 'care' – in French, care means 'to care about' or 'to be interested in' – and it is coupled with technical nursing services. Indeed, there is no good translation from English to French for 'care'. Thus the English word 'care' is used directly in French literature. It is particularly difficult to express in French the two components of care: solicitude/concern for somebody and the practical actions that make care a working activity (Tronto, 2009).

The definition of LTC in France makes use of the OECD definition: The term 'long-term care services' refers to the organisation and delivery of a broad range of services and assistance to people who are dependent on help for basic ADL (bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management).

The central personal care component is frequently provided in combination with help with basic medical services, such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation and palliative care services (OCDE, 2008).

In France, LTC belongs to a specific category separate from health care and social care: the medico-social sector was created in 1975 (law of 30th January) in order to give particular attention to disability and dependency issues. The medico-social sector has become a part of the French social protection system specialised in chronic impairments, whereas acute care is assigned to the health care sector (Bourjac, 2007).

Long-term care covers a variety of services providing health and social facilities related to the severity of needs of people limited in their ability to function independently on a daily basis over an extended period of time.

Available long-term care services include nursing and residential homes, hospital, home nursing care services, home care services, day care centres and support for informal carers that have been developed in recent policies, etc.

In France, about 10% of the elderly and a little more than 2/3 of dependent persons live in nursing homes, whereas home-based care services are usually preferred by the elderly population and supported by public authorities (see section 3 for details).

1.3.2 Who is eligible?

As in most European nations, LTC focuses on older people in France, where the definition of elderly people in laws and used by statistical tools corresponds to the 60 years and over group. This age limit does not represent an appropriate threshold in the ageing process, and still less therefore regarding dependency, which concerns only a small part of the 60 years and over population. The appropriate threshold should be 75 or 80 years.

In theory, all 60 year-olds and over are eligible for LTC services.

Nevertheless, only dependent people (belonging to GIR1 to GIR4 in the AGGIR scale, see appendix) receive benefits in kind (personalised autonomy allowance *APA*, see Benefits section) and only some people receive other cash means-tested benefits (cf. section 2).

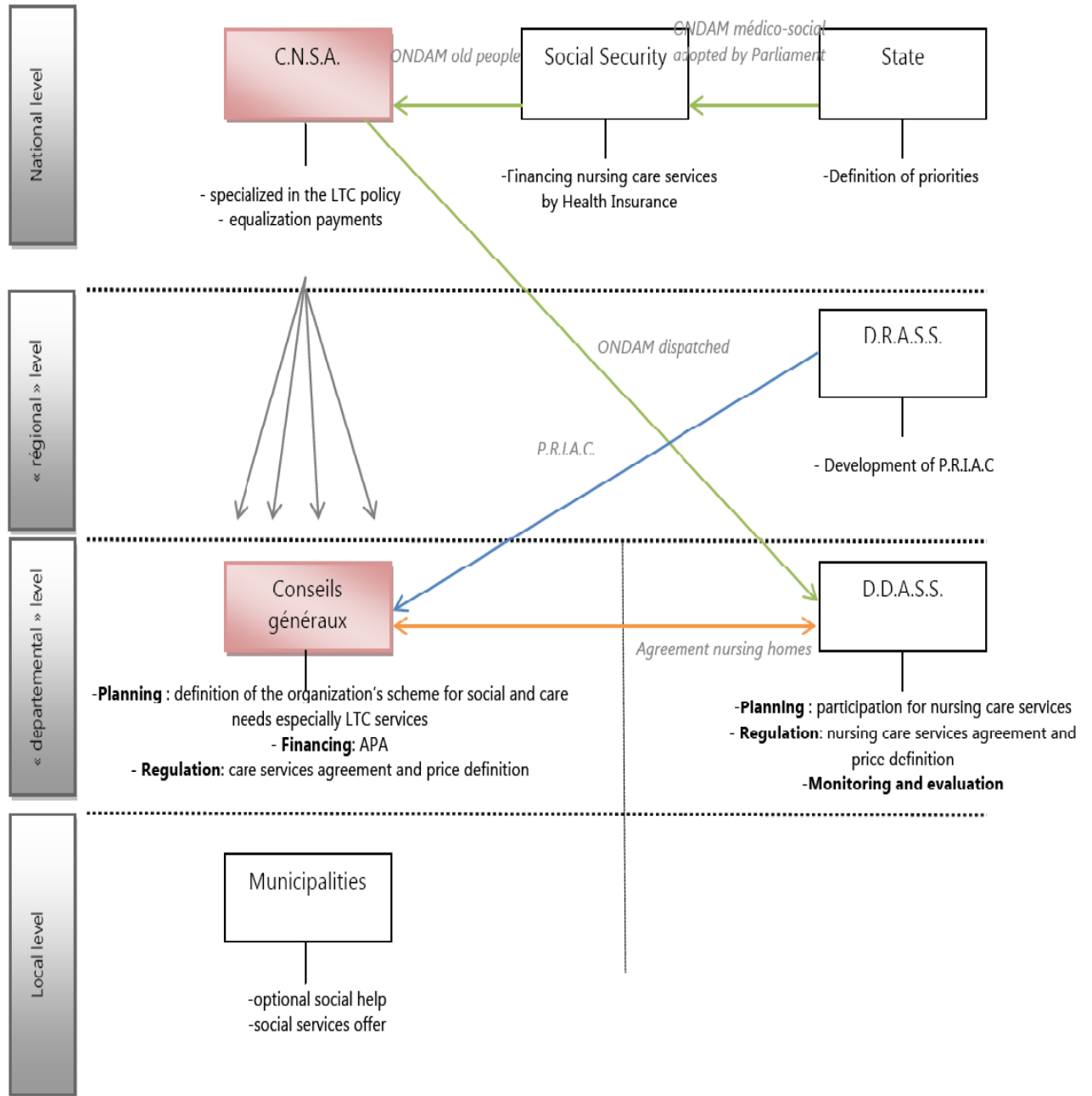
1.4 Management and organisation

The LTC system is based on an original model of decentralised organisation³, where the key role of the 'departmental' level is combined with the National Solidarity Fund for Autonomy (CNSA).

Finally, the roles of the state and the health insurance system are often seen as minor, but should not be neglected (see Figure 1).

³ **Decentralisation:** Each *departement* is administered by a *Conseil général* (general council), an assembly elected for six years by universal suffrage, and its executive. Since 1982, the executive is the President of the council (formerly, it was headed by the Prefect).

Figure 1. LTC actors in France



Source: LEGOS for ANCIEN, 2009

1.4.1 *The National Solidarity Fund for Autonomy – CNSA*

The CNSA (National Solidarity Fund for Autonomy) was created in France in 2004 following the events linked to the 2003 heat wave and in connection with the new disability bill, voted in 2005. These events highlighted the needs of elderly and disabled people for modern social and medical residential facilities and support services, which require increased funding.

The CNSA is responsible for providing financial support and funding for support services to persons who can no longer function independently.

CNSA finances two forms of benefits for elderly and disabled people:

- The Personalised Autonomy Allocation (APA): the APA is allocated and financed by local authorities. The CNSA contributes up to 33% (in 2008) of local authorities' expenses for APA.
- The Disability Compensation Benefit (PCH)

This allowance is dedicated to people whose disability occurred before the age of 60. It is allocated and financed by local authorities, following the decision by the MDPH (services for evaluation of loss of autonomy and special benefits allowance for disabled people). The amount awarded is determined by the level and type of assistance deemed necessary, agreed by the MDPH. 77 500 people received the PCH in 2008. The CNSA contributes 98% (2008) of local authorities' expenses for PCH.

The CNSA's funds mainly come from employers' social insurance contributions, but also from taxes, and reached €13 billion in 2008.

A tax similar to social insurance contributions (0.1% of the "General Solidarity Contribution") contributes €1.1 billion to the CNSA budget.

The "Solidarity and Autonomy Contribution" is a new tax that contributes to financing and modernising services and benefits for the elderly and disabled. It corresponds to 0.3% of a company's total revenue (all employees in French companies donate a day's wage "by working for free"), which represented more than €2 billion in 2008.

The total CNSA budget in 2008 was €16 billion.

The CNSA has three major goals in implementing social-care policies:

- funding services and residences for people with loss of autonomy (€14 billion) and contributing to local authorities' expenses for special allowances (€2 billion);
- ensuring equal treatment for everybody throughout the country: the CNSA distributes its funds in such way as to reduce disparities between regions;
- providing expertise for and diffusing information to its partners: in particular, the CNSA acts as consultant for the MDPH network.

1.4.2 *Local-departmental authorities*

Since the law adopted on 13th August 2004, local-departmental authorities are considered as the 'leaders' in the field of dependency. They have the role of defining policy in favour of disabled elderly people,⁴ planning and coordination, and financing a major part of the personalised autonomy allowance (APA).

They are responsible for defining the organisation of social and care needs in collaboration with the Prefect (the person representing the state at local level).

⁴ Article L. 113-2 du code de l'action sociale et des familles (social action and family code).

The organisation, re-defined every five years, has the following tasks:

- evaluating current and future care and social needs;
- estimating the quantity and quality of supply services and their evolution;
- developing coordination between institution-based care services and the other social and health services,
- defining the evaluation criteria of completed projects.

The departmental authorities grant approval for care services and define the pricing policies of nursing homes and home care services. They allow nursing homes to open or to extend (by approval). They fix one of the three components of nursing homes prices⁵ (the share related to dependency) used for their financing. Moreover, they determine the price section for bed and board in public nursing homes.

The departmental authorities also grant approval for home care services. This approval entitles home care services to display this label for a period of 15 years and to operate on the whole LTC market. The label also implies conformity to regulated prices.

1.4.3 Health insurance

For LTC, health insurance embraces the financing of health/nursing care services (at home or in nursing homes). The budget assigned for this purpose is adopted at national level by Parliament. The annual definition of resources for LTC health care services then becomes the National Target for Health Insurance Expenditure (ONDAM) for the elderly.

1.4.4 The state

The role of the state is to plan LTC policy. The goal remains the improvement of LTC services in terms of quantity as well as quality.

The Parliament (national level) defines the major priorities for LTC. Three plans are particularly significant (see part 4).

The quantitative and qualitative improvement of LTC requires planning. The main planning instruments are the Interdepartmental disability and loss of autonomy assistance programmes (PRIAC). They are defined every three years at 'regional' level and identify the financing needs of nursing homes.

At departmental level, the state participates in the nursing home approval process and agreements for LTC home services.

The priority to improve LTC quality is characterised by an approval or agreement process concluded between the departmental authority, the state and the nursing home. This agreement takes the form of a contract which implies compliance with regulated prices, thus the *State* defines tariffs for health/nursing services.

1.5 Integration of LTC

The quantity and heterogeneity of the different actors who take part in the provision of care to dependent elderly people requires efficient coordination to achieve a global and integrated LTC.

⁵ See Fig 2, section 2.2: In most institutions, the global fee is divided into three parts: **care 'nursing price'** (defined by health insurance); **dependency price** (defined by departments); **housing price**.

The main sectors involved in the provision of care for the dependent elderly are the social and health sectors. A huge range of services exists within these sectors, but both internal coordination and external coordination between them are insufficient.

The French system has developed two main structures to address the lack of coordination within and between sectors: the CLIC (Local centre for information and coordination) in the social sector and the Gerontological Health Network in the health sector. They represent the early beginnings of the case manager concept in France (Blanchard et al. 2008).

1.5.1 Coordination between the social and medico-social sectors

The Departmental authorities (local government) manage CLICs (Local centre for information and coordination), whose role is to coordinate information about access to benefits and institutional or home care for older people. The CLICs are financed by the state and local government. CLICs provide coordination between public and private stakeholders.

The CLIC is a reference structure acting at local level to inform, advise and guide dependent elderly people and their families regarding the different types of assistance they could receive. Its functions are to evaluate the different situations and find the best solution, give information, mobilise resources and coordinate professionals to cope with the situation of the dependent person (Colvez, 2004).

The CLICs not only perform coordination work to meet elderly people's needs. They also coordinate the actions of the professionals involved.

1.5.2 Health sector coordination

The gerontological health networks are coordination structures set up in the organisational health framework defined in every region and they act as reference structures at local level (health area) to organise and coordinate health care for elderly people, mostly with the risk of dependence, in order to ensure continuity of care. This structure brings together professionals from different disciplines to improve the quality of services offered to elderly people.

A gerontological health network can be composed of different structures and professionals: hospitals, clinics and health centres, medical and paramedical professionals, social and medico-social services and organisations and other structures, such as patients' associations.

In a more specific way, the main objectives for an elderly people's network are to:

Evaluate care needs and guide professional assistance;

- Propose personalised and adequate solutions in every case;
- Improve the involvement of the different actors and sectors that take part in care for the elderly: health, medico-social and social;
- Guarantee the continuity of care between hospital and the home or residential institutions and prevent inadequate hospitalisations;
- Promote vocational training
- Promote information and diffusion of common instruments;
- Perform prevention activities;
- Perform qualitative evaluations linked to the perceptions and satisfaction of patients and families.

At present, neither system has really succeeded in integrating medical and social sectors for the elderly. Each of them is organised around a specific function without providing a transversal vision: the CLICs promote local public policy whereas gerontological networks promote health

sector organisation. Furthermore, there are major disparities between Departments, which are at different stages of development.

Consequently, associations are often in charge of integration for home care and home health services, but their actions are not well-organised. They depend on services proposed by the providers. Home care services are represented by two main federations and often manage integration through the different types of services they propose. Local government also plays this role at the municipal level.

Finally, the current system does not satisfy all needs. Moreover, the different attempts to coordinate stakeholders have made the LTC system more complex.

2. Funding

2.1 Total expenditure for LTC

Expenditure for long-term care is difficult to quantify precisely.

Indeed, public expenditure depends on many different stakeholders (central government, local-departmental government, municipalities, social insurance and CNSA) and financing flows are very complex.

Private expenditure, i.e. private insurance and user charges, is more difficult to estimate. In addition, there are major differences, for instance, in the accommodation fees of nursing homes.

The French LTC system is a mixed system: it is based on Beveridge's and Bismark's models (both taxation and insurance contributions) and with family-based characteristics. Families play a central role in financing and caring.

The French LTC system is financed by:

- taxes: the system is inspired by Beveridge's model. The personalised allowance for dependency is financed by national taxes (see CNSA) and local taxes (own resources of Departmental authorities). Furthermore, LTC is a universal right because persons receive benefits if dependent, whatever their income.
- contributions: a major share is financed by social contributions through social insurance: indeed, a large share of LTC is funded by health insurance.
- Families: a major share of LTC is financed by families whose role is becoming increasingly recognised.

Moreover, municipalities and private insurances can provide optional social financial resources.

Thus total expenditure on LTC was estimated at €25 billion in 2007 (Sénat, 2008).

A large share is financed by public stakeholders (€19 billion), which amounts to 1% of GNP (Cour des Comptes, 2008). Of this public expenditure, 60% is financed by health insurance, 20% by local government, 15% by the CNSA and 2% by the central government (through indirect expenditure such as tax exemptions).

We can therefore consider the French system as a social finance system. However, there is a major cost-sharing element.

Institutional care and home care are not financed in the same way.

2.2 Funding sources for LTC institutions

Public expenditure only for dependent people living in institutions is estimated at around €3 billion.

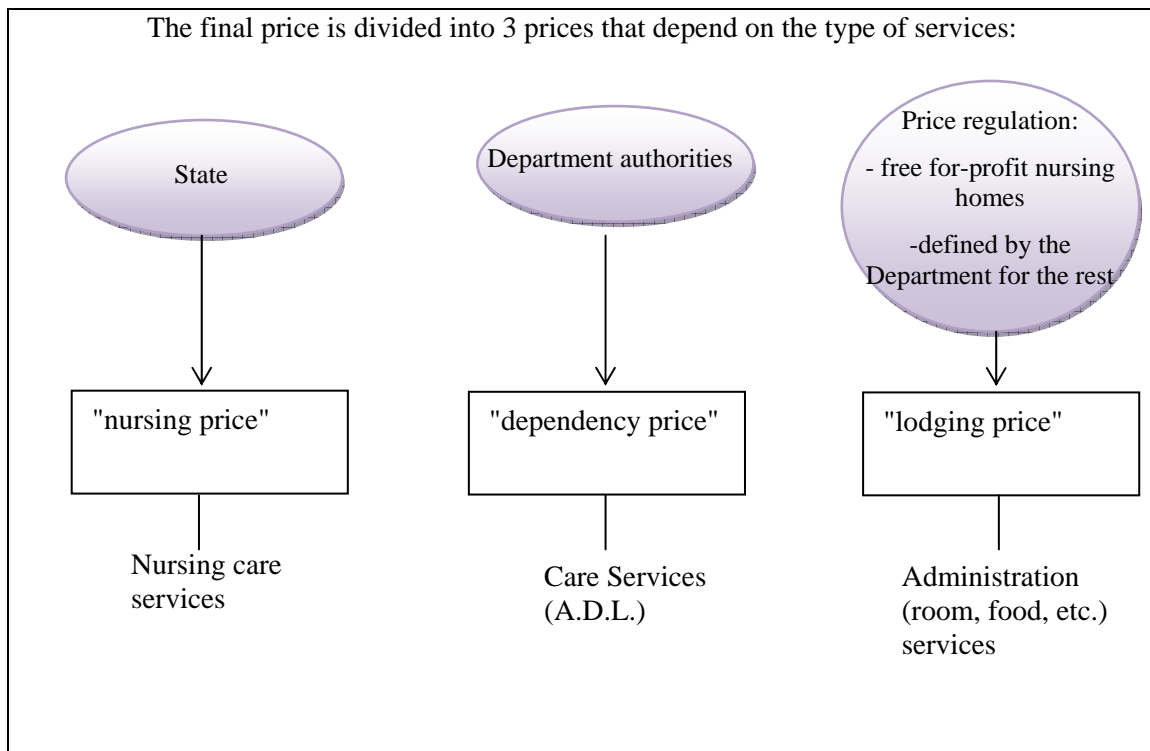
It includes (Sénat, 2008):

- expenditure for health care: €5.2 billion;
- APA payments specifically for people living in institutions: €1.4 billion
- social housing aid:⁶ €1.1 billion
- fiscal exemptions: €1.6 billion

In most institutions, the global fee is divided into three parts (see Figure 2 and part 3):

- **care ‘nursing price’**: defined by health insurance
- **dependency**: partially covered by APA
- **housing; ‘lodgings’**: paid by the user.

Figure 2. Institution price regulation (if a tripartite convention has been signed - EHPAD): 3 components of the price: nursing/dependency/lodgings



For institutions, housing fees represent 60% of costs, care fees 30%, and dependency fees 10%.

Accommodation costs vary between different institutions, from €33 to €80 per day, or €12,000 and €29,000 per year. Since about 500,000 persons live in institutions for dependent persons, the amount paid by households was estimated to be around €6 billion in 2007 (Sénat, 2008).

⁶ Solidarity Housing benefit (ASH) allowed by the Department authority.

However, we do not take into account housing benefits, which represented €68 million in 2007 for institutional care.

2.3 Public Expenditure for home services

Public expenditure for home care and home health for LTC was estimated to be around €6.6 billion (Cour des Comptes, 2003).

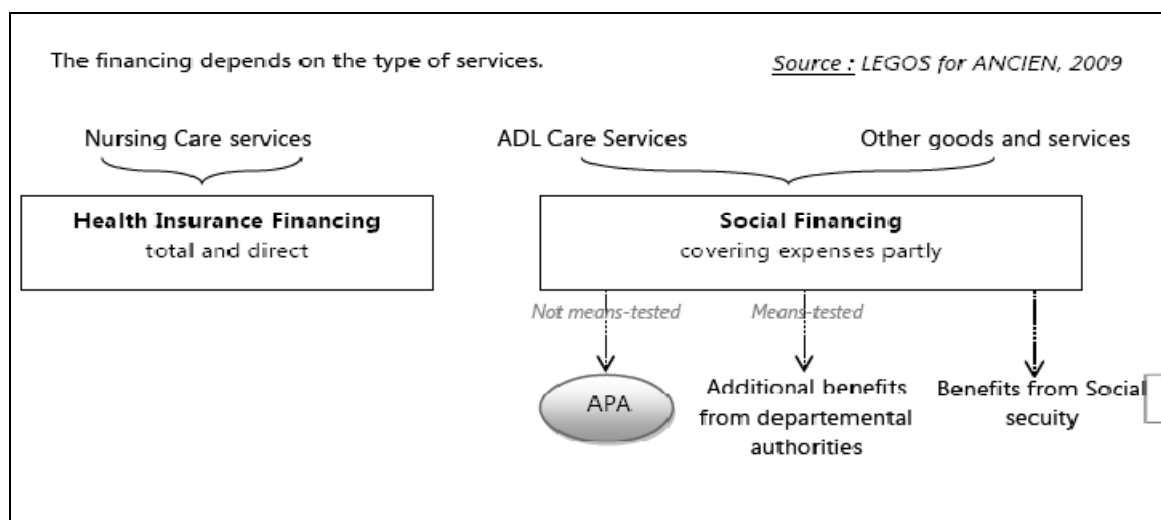
For home care, public expenditure includes:

- APA for dependent people living at home, (€4.5 billion in 2007) (Espagnol, 2008);
- benefits from social insurance from retirement social insurance (€0.3 billion in 2007);
- housing benefits from family social insurance could be added but they are not specifically allocated to dependent people.

Home nursing care is financed by health social insurance, which amounted to €1 billion in 2006 (Fenina, Goeffroy, 2007).

Health/nursing care is financed by health insurance (see Figure 3), including health/nursing fees in institutions and home health/nursing care. Consequently, health insurance is the first public stakeholder financing LTC (60% of the total public expenditure for LTC).

Figure 3. Financing and type of services



2.4 Benefits

Personalised allowance for autonomy (APA) is the main allowance in LTC. APA is intended for people over 60 years to support expenses linked with their new loss of independence. It can be allocated for people who decide to enter a residence or remain at home, or to assist them in their daily lives. The amount allocated is determined as a function of the individual's level of dependence and their disposable income.

Public expenditure for APA was about €6 billion in 2008 (€4.5 billion for people staying at home, €1.4 for those in institutions) for 1,115,000 people.

The average APA benefit is about €490 for a person at home and €410 for one in an institution (Prévo, 2009).

APA is a universal right based on a social assistance scheme, and is managed at 'departmental' level by Departmental authorities. It guarantees the same benefit levels everywhere in France.

APA is a benefit in kind: *APA* can be granted either to dependent elderly people living at home or to those living in nursing homes, to help them overcome the difficulties they face in carrying out their daily activities.

APA aims to finance a personalised assistance grant.

Departmental authorities are in charge of assessing the dependent person's needs and they evaluate the final implementation of the care package.

To be eligible for APA the person must live in France, be aged 60 and over and have a recognised dependency need. The severity of the latter is established by the AGGIR scale.

The benefit is no longer means-tested but the amount is reduced progressively (from 0% to 80%) for beneficiaries, in line with their income.

The assessment process comprises three steps: i) a request from the old person, ii) evaluation by a social and health team (medical doctor, nurse and social worker) and definition of the care package, iii) final agreement for benefits by 'departmental' authorities.

Other benefits also exist.

Different social insurance agencies allocate benefits to all people and not only specifically dependent people. For instance, retirement insurance proposes benefits in kind such as home assistance for people whose dependency level is not severe enough to receive APA.

In addition, family insurance allocates housing benefits in cash. For people living in institutions, it amounted to €568 million in 2007.

A major share of support comes from tax advantages:

- people living in institutions benefit from tax exemptions on their income;
- for home care, people can deduct tax if they employ persons at home, and for expenditure on medical equipment relating to dependency.

These tax exemptions amounted to €70 million in 2008.

2.5 Cost-sharing/out of pocket expenditure

Cost-sharing for families is still important for LTC financing (about €7 billion). Average costs for a dependent person have been estimated in national reports. For a very dependent person (Gir1-Gir2) it varies from €1,500 to €4,000 monthly at home;⁷ in institutions the average monthly fee varies from €1,300 to €2,000.

2.5.1 Formal home-based care

In 2008, the maximum monthly amount of APA for a very dependent elderly person living at home (GIR1, see definition in Annex 2) was about €1,209; for a less dependent person (GIR4), it was about €18.

Moreover, the maximum amount of APA does not usually cover the total cost for very dependent elderly people.

⁷ According to the number of hours of help (from 3 to 12 hours per day) Gisserot (2007), *Cour des comptes* (2005).

For people at home, an average APA benefit is about €490 (Prevot, 2009). The APA benefit is not means-tested but the amount is reduced progressively (from 0% to 80%) for recipients who have resources in excess of €77.25 a month (in 2008).

On average, cost-sharing amounts to €88 (18% of €490). Concerning home health and home care, families paid €550 million in co-payments in 2007.

2.5.2 Formal institutional care

For institutional care, families spent at least € billion in 2007, including accommodation expenditure and a share of dependency fees.

Indeed, expenditure for room, food and so on (bed and board) are paid fully by the recipient if they do not benefit from additional assistance from local government (Allocation de Solidarité pour l'Hébergement (ASH) (solidarity allocation for housing).

APA co-payment in institutions is composed of:

- a constant amount based on the lower level of dependence (GIR 5 and GIR 6 of AGGIR scale) rates (about €4 or €5 a month)
- and a means-tested participation.

The average amount of cost-sharing is around €1,600 per month (€1,500 for lodgings + €100 for dependency).

Daily fees at national level are not known (National Assembly, 2006) and few samples provide information on the heterogeneity of daily fees between departments, between rural and urban areas, between public and private providers, and between facilities.

In all likelihood, the brackets could be: from €17 to €60 per day for the 'nursing price', from €10 to €27 for the 'dependency price' and from €33 to €80 for 'bed and board'.

Only the average monthly 'dependency price' is known:

- * €47 for Gir1 and Gir2;
- * €335 for Gir3 and Gir4;
- * €5 for Gir5 and Gir6 (Prévot, 2009).

No national data exist permitting the precise evaluation of fees and cost-sharing in institutions. Major differences exist between public, non-profit private and profit-making institutions. However, fees are estimated to be around €2,000 per month in for-profit institutions and €1,300 in public institutions. Housing fees are fixed freely when there is no *convention tripartite*⁸ with Department-local authority and devolved administrations (local representatives of central government).

Due to the shortage of beds and possible waiting lists, elderly people cannot always choose their institution; consequently they may have to opt for a private institution in order to have a place, even if it is more expensive.

Total cost-sharing is estimated at around €7 billion for 2007. Moreover, the private insurance sector is developing slowly in France (Dufour-Kippelen, 2008). Insured persons spent €373 million in 2007 on private insurance premiums (Sénat, 2008).

⁸ A 'convention tripartite' is a convention signed between state, department and an institution (see part 3.4).

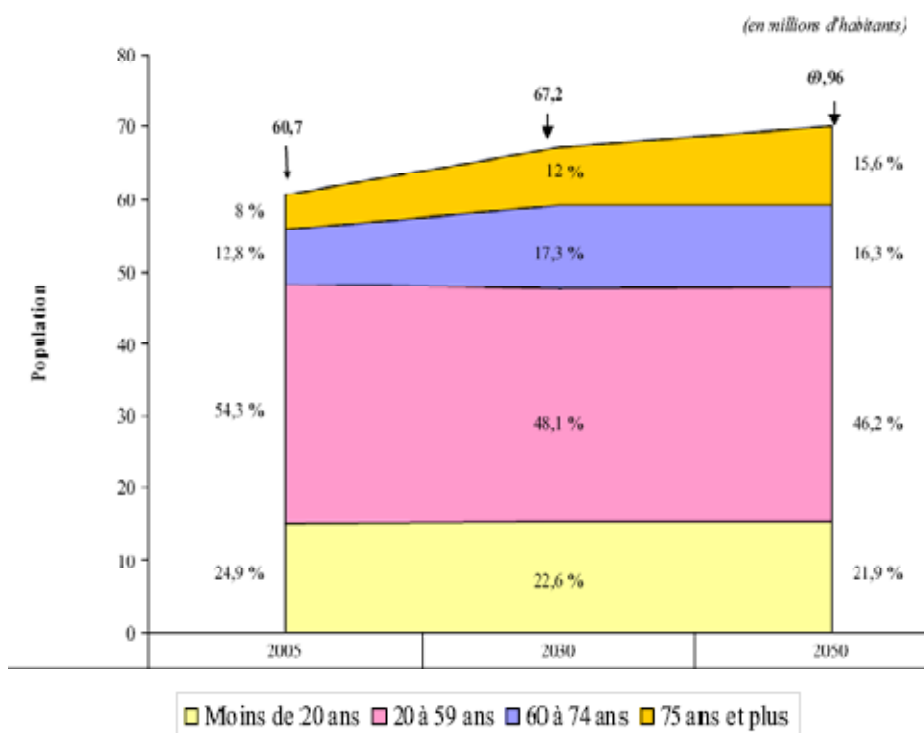
However, tax benefits can reduce cost-sharing and tax benefits for dependency amount to about €500 million.

3. Demand and supply of LTC

3.1 The need for LTC

The sector of the population aged 60 years and over was 12.6 million in 2005 (22% of the French population), and will reach 20 million in 2030, and about 22 million in 2050, which will be equivalent to almost one third of the whole population (see Figure 4). The population aged 80 and over (age when dependency usually increases very fast) will reach 4 million in 2020 (+80% in comparison with 2000) and 7 million in 2040 (a threefold increase compared to 2000) (Colin, 2000).

Figure 4. Structure of the French population from 2005 to 2050



Source : Insee première n° 1092 – juillet 2006.

Source: Sénat (2008) p. 85.

Obviously, it is not easy to estimate precisely the number of elderly persons who need care. The bracket between 628,000 and 1,516,000 is considered correct in the literature. If only heavy dependency is taken into account (Gir1 to Gir4 in AGGIR Grid, see Appendix 2), the bracket is reduced to 850,000 persons (Colin, 2003).

According to average forecasts, a large increase in the number of very dependent persons is expected by 2040. This growth would be not linear and would be characterised by two boosts in 2015 and 2030.

3.2 Role of formal and informal care

In France, 12 million people aged 60 and over (and a third of people aged 75 and over) live in a private household. 28% of the 12 million people aged 60 and over, i.e. 3.2 million (57% of whom are women) are in need of help in their everyday lives.

The high number of people living at home is mainly possible due to widespread family care, and to a lesser degree to professional domiciliary care. High dependency (mainly in advanced old age) generally leads to a mix of informal and formal assistance. 50% of these 3,230,000 informal care recipients receive exclusively informal care and 29% receive both informal and formal LTC. Single persons usually receive formal assistance to compensate for the lack of informal care.

3.3 Informal care

The number of informal carers is not easy to estimate. According to HID survey data, there are about 3.5 million informal carers (Dutheil, 2001) (all levels of dependency). From the same data, it can be estimated that there are at least 300,000 informal care-givers for very dependent elderly people.

3.3.1 Who are informal care-givers?

There is a clear predominance of informal care-givers, and 85% belong to the family of the 'cared-for' old person. However, informal care-givers also include neighbours and friends (9%) in particular for single people living at home. Among these care-givers, 66% are women.

Intergenerational relationships within the family remain important (Aptel et al., 1997). In particular, elderly care by a descendant is based on the notion of giving and receiving at different periods in life. 50% of main care-givers are spouses and 30% are children.

The main care-giver is typically a woman (6/10) when the partner/spouse is the main care-giver and 7/10 when the child/child in law is the main care-giver.

Older men are mainly cared for by their wives, while older women, often widowed, are mainly cared for by a daughter (Bocquet et al.). Due to longer female life expectancy, adults are likely to care for their mothers or mothers-in-law.

The highest likelihood seems to be that someone will become a family carer at the age of between about 60 and 75. When the care-giver is the spouse, the average age is 70; when they are the child, the average age is 51.

3.3.2 Caring tasks

When considering need in the case of dependency, it is not surprising that housework is the main area of care provision, or that these daily tasks are performed by formal (51%) as well as informal (42%) care-givers. When the care-giver is the spouse, they perform particularly personal hygiene tasks and housework whereas the help provided by children is usually in the form of administrative tasks (defence of personal interests, etc.). Women usually also perform personal hygiene and housework tasks.

3.3.3 *Care policies for family carers*

The severity of needs is correlated to the consequences of being a care-giver: almost 42% of informal care-givers for very dependent relatives declare having negative consequences, especially psychological (3 in 4) and physical (50%).

Although the family is the main provider of care for the elderly, there is no real 'care for the carer' policy in France. This does not mean there is no attempt to contribute some support to informal care-givers. The "Conference for the Family" in 2006 focused on the subject of intergenerational solidarity within families and drew up several guidelines on the combination of working and caring, better valuation of informal care and the development of respite services.

The combination of working and caring is unquestionably difficult, particularly for those who work full-time.

Two measures to support working carers were adopted. On the one hand, since 2007 (decree of April 20th), working carers can benefit from the right to leave their job for three months without losing retirement rights. On the other hand, a policy project is being debated about a process of recognition of the competences of informal care-givers, in order to make professional reintegration easier.

Three measures tend to increase the value of informal care:

- The creation of a specific status of informal care-giver in law.
- the creation of 'the informal care-givers' notebook' which gives information to the care-givers about their rights;
- the possibility for informal care-givers to be paid, thanks to the APA allowance.

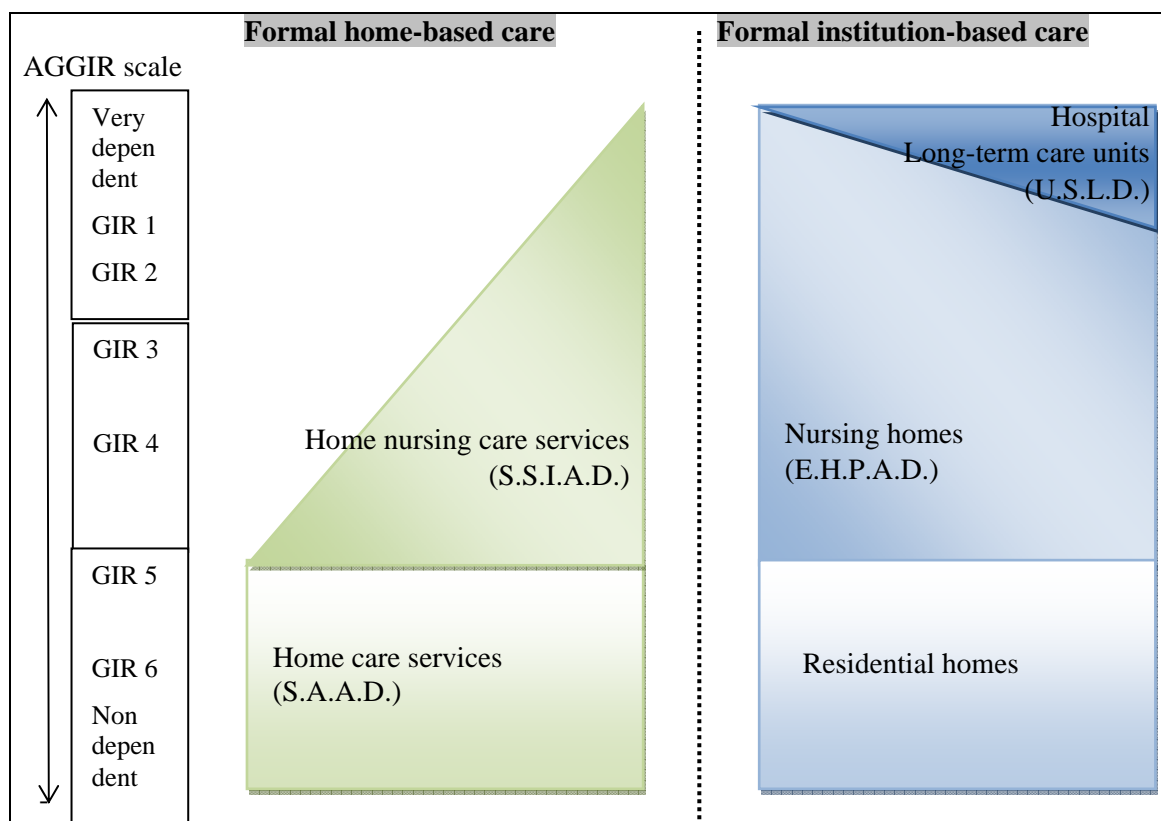
In order to face the burden, informal care-givers can appeal to training services and collective actions to give them moral support. Moreover, the alternative solution to informal care at home was to create 2,500 places per year in day care services, provide 1,100 beds for temporary stays and develop respite care services at home.

The availability of family carers over the next few decades is expected to decline. Projections from the National Office for Statistics (INSEE) state that the increase in numbers of the potential carer generation (aged from 50 to 79) will be slower than that of the dependent elderly. This shortage could be exacerbated by the possible increase of female participation in the labour market of women aged 55 and over (as previously stated, women constitute the majority of care-givers).

3.4 Formal care

Available formal care services are summarised in the following figure.

Figure 5. Formal LTC services in France



3.4.1 Institution-based care

Institutions for elderly people group together social and health/nursing residential services for elderly people and currently take in more than 640,000 recipients of care.

Three types of institutions are usually distinguished:

- residential homes or sheltered housing;
- nursing homes (Residential care for elderly people and Residential care for *dependent* elderly people);
- LTC units in hospital (USLD).

The whole area of nursing and residential homes for old people has been strictly regulated since 1975 (law no. 75-535 on 30th June 1975).

A new article in the legal framework was added by an act in 1997 (law no. 97-70 passed on 24th January 1997). The term Residential care for *dependent* elderly people (usually referred to as *EHPAD*) was introduced for institutions able to provide care for dependent elderly people.

In the long run, all nursing homes whose care recipients are very dependent (belonging to Gir1 to Gir 4 to the AGGIR scale) should become EHPAD.⁹ Legal status is obtained after an agreement process called *convention tripartite* in French.

The *convention tripartite* results from an agreement process. It is a kind of contract concluded between three parties (local-departmental government, the government representative in the region, and the nursing home) and finally delivered by the local-departmental authority.

It implies conformity to regulated pricing and quality objectives. This regulation reflects the will to consider the specificity of LTC.

EHPAD status is appreciated with regard to a quality standard because it is assignment as a function of conformity with quality rules which brings to mind comparison to a label. Indeed, the concept of 'label' refers in France to quality certification by public authorities.

a) Capacities

There were 10,305 nursing and residential homes in 2007, corresponding to 684,000 places (around 66 places/facility) for 657,000 care recipients.

Among these 10,305 institutions, there were 6,850 EHPAD institutions (67% of total institutions) for 515,000 places (75% of total recipients).

Table 1. Capacities and residents in institutions for elderly people (Prévoit, 2009)

	Beds	Structures
Residential home	142 913	2 786
Nursing homes	471 102	6 504
Highly medicalised nursing homes	68 142	903
Others (very short-term homes, experimental, etc.)	2 002	112
Total	684 159	
Residents in 2007	657 000	

The number of places per 1,000 is decreasing: in 2008 the national average ratio was 127 places per 1,000 elderly persons (75 years and over); in 1996, it was 166 places per 1,000 and 140 per 1,000 in 2003.

Indeed, between 2004 and 2008, the population aged over 75 increased much faster (+14%) than the number of places.

Although these trends should be put into perspective because of the increasing age of entry into dependency and because of the development of home-based LTC services, the question of supply/demand balance must be raised.

There are no national data on waiting lists: the occupancy rate is estimated to be about 97%.

Some inquiries into levels of satisfaction seem to indicate the existence of waiting lists and of difficulties for families in finding a bed.

⁹ On December 31st 2007, 88% of nursing homes, 74% of LTC units in hospital and 16% of residential homes became EHPAD.

Geographical inequalities are significant. Indeed, the number of facilities is not proportional to the number of elderly people in need of them. Elderly people usually live in rural areas (except Paris) and in the south of France, but there are more facilities in the east and west of France.

b) Type of providers

Empirical studies on the French case are limited to consultant reports (Ernst & Young (2008), Candestic (2007)). They conclude that the French market is still not consolidated because of movements of 'privatisation', concentration (the quest for critical size) and incipient internationalisation.

The global trend is towards the decline of the family and fewer independent structures, due to the financial burdens imposed by compliance with severer security and technical standards (which contribute to improved quality).

Public structures remain preponderant (60% of beds in 2007) and non-profit nursing homes remain in the majority among private homes (26% of beds). However, the for-profit sector is growing and accounted for 14% of beds in 2007.

Competition is especially evident between private for-profit providers. Even if competition exists between private not-for-profit providers, it is however limited because their status imposes certain rules, like a ban on advertising. Private for-profit providers are becoming more and more powerful on the market, with five taking the foreground: Korian, Orpéa, Dolcéa, Medica France and DomusVi.

Another current trend is the diversification of services (medicalisation, institutional short-term care and day care services, and a special housing and care concept for older people suffering from dementia such as Alzheimer services (see section on Reforms), in order to benefit from economies of scale.

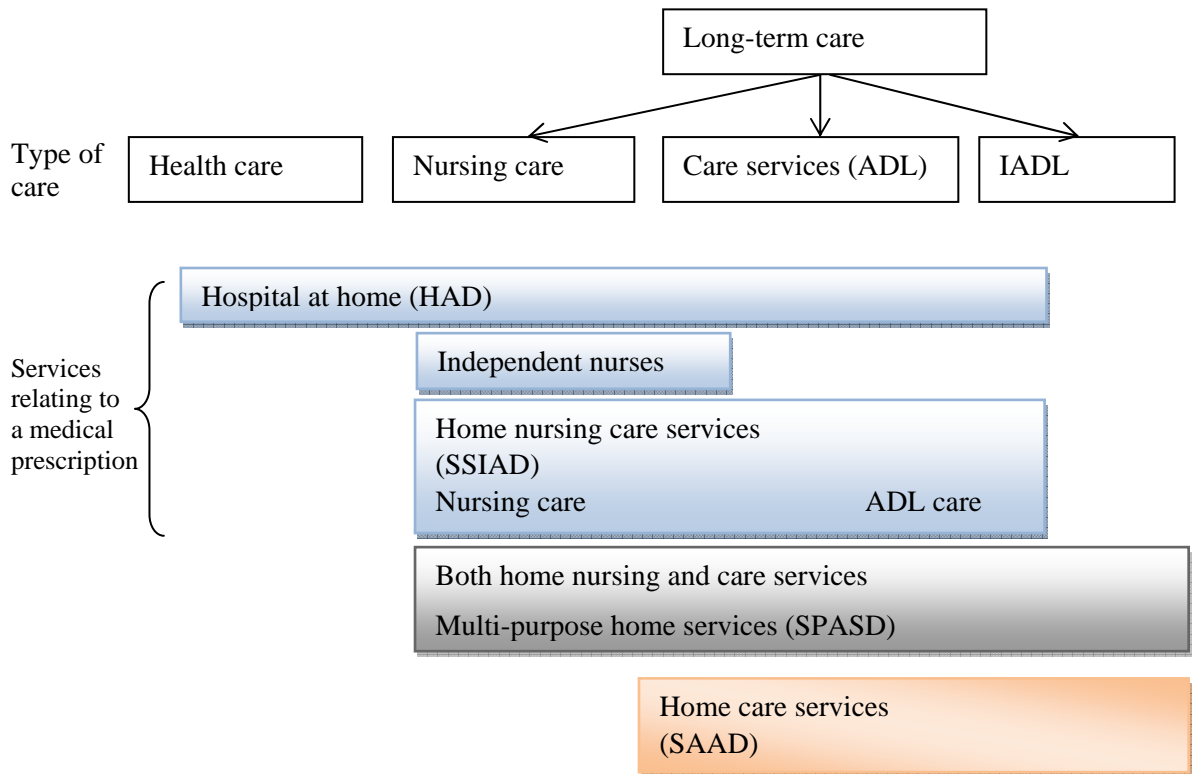
3.4.2 *Home-based care services*

At home, dependent elderly people need technical assistance and specialised help in their daily living activities, in order to maintain an adequate environment.

The French home services for older people include a wide variety of help and support. The system relies on different services to cope with social and nursing needs (Figures 6 and 7).

- home nursing care services (SSIAD,) included in the health sector;
- home care services (SAAD,) that have belonged to the medico-social sector since 2002 (law of 2 January 2002);
- multipurpose home care services (Spasad) created by the decree of 25 June 2004; they group social and nursing services. There are actually very few of them.

Figure 6. Home care: Diversity of services



In theory, the difference between home nursing care and other types of home care is based on the level of care and the severity of need.

Nursing services are committed – *only on medical prescription* – to administering injections, bandaging, taking blood, urinary and faecal samples, giving vaccinations and so on.

Minor tasks or personal care are usually provided by an auxiliary nurse.

SSIAD support and maintaining daily living activities linked to the loss of autonomy at home and within the social environment (hygiene, accompanying tasks, cleaning, cooking, etc.). Freelance nurses also dispense health care (technical and basic care) at home.

However, the borderline between home nursing care and home care is not an easy one to draw, especially when sharing out tasks between paramedical staff and social helpers for ADLs. Paramedical staff perform services that could be provided by a SAAD (*home care services*); on the other hand, because of the lack of beds in SSIADs (*home nursing care services*) and insufficient coordination, SAADs provide nursing services.

Home nursing care services (SSIAD) are directly and wholly financed by the national health insurance scheme.

Figure 7. Number of Home Care structures

SAAD	6,251 SAAD on December the 31st2002
SSIAD	2,028 SSIAD = 91, 478 places on December 31st, 2006**
Independent nurses	68,000 nurses on 31 December, 2006**
HAD	9,067 places in 2007***

Sources:* Dares, "Dynamisme du secteur des emplois familiaux en 2002 ", in Premières informations, premières synthèses n° 51.1, décembre 2003
 ** Data from DGAS (Health Ministry)
 *** Data from DHOS(Health Ministry)

In 2006, there were 2,028 SSIADs for 91,479 places and 68,000 liberal nurses. SSIAD capacity has therefore greatly increased since their creation (only 3,500 places in 1980). According to the Ministry of Health, 13% of home visits are provided by freelance nurses working for SSIADs.

The national supply rate is 10 places for 1,000 elderly persons aged 70 years and over and the average capacity of one SSIAD is 40 places.

If we add the number of home nursing-helpers working in a SSIAD and the number of freelance nurses, we obtain a global indicator of the density of home nursing-helpers. The analysis of this indicator highlights certain geographical inequalities in France, especially between the north and the south of the country.

SSIADs are usually considered as an alternative to hospitalisation. In 2002, 71,000 persons were SSIAD care recipients. More than 2 out of 3 recipients were 80 years old and over; 1 in 4 were totally physically dependent and 45% were psychologically dependent.

Care-givers are mainly nursing aides who represent 80% of employees and provide 80% of visits, whereas nurses perform coordination tasks.

More than 30% of home nursing care services are managed by public organisations (hospital, medico-social institutions and municipalities). Almost 2 out of 3 places are provided by private non-profit making associations.

4. LTC policy

4.1 Policy goals

Laws and general policies are defined at national level: laws are adopted by Parliament and national plans are drawn up in line with the orientation given by the government.

In recent years, *Ageing and Solidarity Plans*, *Alzheimer plans* have defined the major priorities for LTC.

The *Ageing and Solidarity Plans* for 2004-2007 and for 2007-2012 have had four main objectives:

- Strengthening APA benefits;
- Giving preference to home care services;
- Modernising and improving medical care services in nursing homes;
- Developing geriatric services.

The *Alzheimer plans* (2001, 2004, 2008) demonstrate the national priority for mental disability.

The first plan (2001-2005) focused on Alzheimer diagnosis and announcement, and the support needed by people suffering from this illness, and by their families.

The second plan (2004-2007) focused on the development of appropriate care services.

The third plan (2008-2012) focuses on the coordination between health and social care services, the reinforcement of home care services, informal care, training and the development of new care services.

This third plan is much more ambitious than the first and second (in terms of financing and media interest) and aims to organise integrated care for Alzheimer patients.

It consists of setting up Houses for Autonomy and Integration for Alzheimer Patients (MAIA) which are the only places to obtain information, coordination and care for sick persons and their families. They use all existing organisations: CLIC, cooperation organisms, etc.

In each MAIA, a professional will act as 'case manager' and be the sole interface with the person and their family. The ultimate objective is to generalise this type of organisation for all dependent people.

In addition, a project called PRISMA (Research project on Integrating Home Care Services integration,) is currently being tested. It involves in putting in place a sole intermediary to inform, be attentive to and coordinate all the stakeholders in LTC, with the objective of making the system more integrated.

In brief, the main national objectives are:

- *To delay dependency*, by preventing social isolation, developing intergenerational links and the social role of older people and improving older people's living environments
- *To support home care*, by developing home services and networks and helping informal care-givers
- *To improve institutions* (more places, better quality, etc.)
- To train professionals
- To support research and prevent specific diseases of old age
- To propose specific care for persons affected by Alzheimers
- To combat mistreatment
- To develop quality evaluation
- *To draw up a new mode of financing for dependency* (for example, make demand solvent through benefits).

4.2 Recent reforms and the current policy debate

Two reforms are now underway: the creation of Regional Health Agency (ARS) and Dependency Insurance.

For long-term care (LTC), the HPST bill also introduces new regulatory tools aimed at solving problems of coordination between the social and health care sectors. The current legislative reform poses particularly relevant questions about local government as the appropriate level for LTC regulation. The creation of ARS (Regional Health Agencies) from 1 January 2010 (in the recent law (2009) on Hospital, Patients, Health and Territories (HPST)), is aimed at simplifying the administrative structure by joining, at regional level, devolved administrations (local representatives of the Central State), Regional Hospitalisation Agencies (ARH), and local social

insurance services. Overseen by the regional prefects, ARS will manage the overall delivery of care, whether private, hospital or medico-social.

They will be competent to regulate the health and long-term care sector (supply) in their territory in order to provide continuity to care. The objective is to coordinate the sector of health, the social sector, hospital and private practice, in both public and private sectors.

The debate is still open about the creation of the new risk termed “dependency” in social insurance and/or a compulsory private long-term care insurance scheme (Assemblée Nationale, 2010).

4.3 Critical appraisal of the LTC system

The LTC system comprises different problems.

Local inequalities are significant regarding the amount of benefits (APA at home) while the supply of beds differs between ‘Departments’.

High out-of-pocket expenses lead to significant inequalities between elderly people.

Although the creation of the *convention tripartite* has contributed to improving quality in institutions there is still a lack of control regarding the quality of services. In addition, in the case of home care, there is a lack of evaluation and thus quality remains an unknown factor.

Complex governance leads to a lack of coordination, which may be simplified by setting up ARS (Regional Health Agencies). In addition, the complexity of financing channels has been criticised for the resulting lack of transparency.

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Appendix: AGGIR scale

The AGGIR grid is the national standardized instrument aimed at determining the dependency of old people in France living in institutions as well as in the community.

The AGGIR grid evaluates loss of autonomy by using 10 criteria:

1) Coherence; 2) Orientation; 3) Toileting; 4) Clothing; 5) Food; 6) Urinary and faecal continence; 7) Transferring; 8) Movement indoors; 9) Movement outdoors; 10) Telephone communication.

AGGIR splits the population into 6 groups:

GIR 1: elderly people confined to bed or chair, with seriously impaired intellectual functions, essential continual presence of health care personnel.

GIR 2: two groups of elderly people

- Those confined to bed or chair, with intellectual functions not totally affected, but needing assistance for most activities of daily living
- Those with affected mental functions but who are still mostly able to move around

GIR 3: elderly people who have retained their intellectual faculties and part of their ability to move around but who require assistance several times a day for their physical autonomy. Most of them need help going to the toilet.

GIR 4:

- Those who are unable to get up on their own, but once up can move around indoors. They sometimes need help with washing and dressing. Most of them can eat without assistance;
- Those who have no problem in moving around but need help with bodily functions and meals.

GIR 5: people who can move around inside their home without assistance, and can eat and dress themselves alone. They require occasional help with washing, preparing meals and doing housework.

GIR 6: people who have not lost their autonomy for daily living activities.

Acronyms used

APA	Personalised allowance for autonomy
ARS	Regional Health Agency
ASH	Solidarity housing benefit
CAS	Centre for strategic analysis
CCAS	Community centre for social action
CLIC	Local centre for information and coordination
CNAF	National family-allowance fund agency
CNAV	National pension fund
CNSA	National Solidarity Fund for Autonomy
COR	Pensions advisory council
DALO	Enforceable right to housing
DOM	Overseas department
DREES	Division of research, studies, assessment and statistics
EHPA	Residential care for elderly people
EHPAD	Residential care for dependent elderly people
HPST	Hospital, patients, health, and territories Law
INSEE	National institute for statistics and economic studies
LOLF	Organic law relative to finance laws
MDPH	services for evaluation of loss of autonomy and special benefits allowance for disabled people
ONDAM	National Target for Health Insurance Expenditures
PCH	Disability compensation benefit
PSD	Specific allowance for dependency
PRIAC	Interdepartmental disability and loss of autonomy assistance programmes
SAAD	Home care/help services
SSIAD	Nursing care services at home
SMIC	French national minimum wage
USLD	Long-term care units in hospital

About Université de Paris-Dauphine, Laboratoire d'Economie et de Gestion des Organisations de Santé (LEGOS)

Since its creation in 1973, the Laboratoire d'Economie et de Gestion des Organisations de Santé (LEGOS) has been active in research, teaching and consulting in the field of the economic analysis of health and social policy, notably health economics and public policy, the structural and institutional evolution of the public and private health care system and options for decentralisation and regulation. Its research includes health and social economy, chronic diseases analysis and more particularly economics of ageing.

ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

L launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).