Contribution to the 2021 SPC-COM report on long-term care for older people in the EU France

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ESPN Thematic Report: Contribution to the 2021 SPC-COM report on long-term care for older people in the EU

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Highlights

- 23.9% of the French population will be 65 or over in 2030. Based on the French long-term care (LTC) indicator, i.e. the number of people aged 60 or more who receive Personal Autonomy Allowance (APA), the estimated number of recipients will increase from 1,265,000 in 2015 to 1,582,000 in 2030 and 2,235,000 in 2050, which is a growth rate of 76%.
- LTC public expenditure, representing 1.7% of GDP (currently evaluated at €23.7 billion – national data), constitutes a major, although fragmented, financial investment in France, and could reach 1.9% of GDP by 2030. In addition, the cost of informal care provided by 3.9 million carers has an estimated value of between €7 billion and €18 billion.
- Improving access to and the affordability of LTC services is a major concern that is managed by reducing out-of-pocket expenditure and developing coordination between the health and social care sectors.
- Despite real investment in developing a specific social care employment sector, a key challenge facing France today is the reorganisation of the LTC workforce.
- Since the Act on adapting society to an ageing population of December 2015, no comprehensive LTC reforms have taken place in France. However, the major guidelines of a deep-seated reform were presented in the Libault Report (2019), which includes a recommended investment of almost €10 billion in LTC by 2030.

1 Description of main features of the long-term care system(s)

1.1 Demographic trends

In 2019, the old age dependency ratio in France was 32.5 and is set to reach almost 40% in 2030 and 49,3 % in 2050, according to EU estimations of fertility rates and life expectancy at birth[1]. This scenario is somewhat debatable. For example, it considers a stable fertility rate of 2 children per woman for the next 30 years, which is not the trend observed at national level (a slow but regular decrease from 2.03 in 2010 to 1.87 in 2017).[2]

In 2019, 13.5 million people were aged 65+ (7.7 million women and 5.8 million men), representing one in five of the total population (20.1%). Projections for the next decades are as follows: in 2030, the 65+ population would represent 23.9% of the total population (16.4 million – 9.2 million women and 7.2 million men); in 2070, the figure would be 19.1 million (10.7 million women and 8.4 million men) representing more than one quarter (26.6%) of the total population. These calculations take into account the evolution of life expectancy at 65. In 2019, life expectancy at 65 was 21.3 years (23.8 years for women and 19.7 for men). For the next few decades, EU estimations are as follows: for women, 24.6 years in 2030, 26.1 in 2050 and 27.5 in 2070; for men, 20.8 years in 2030, 22.5 in 2050 and 24.0 in 2070. According to these estimations, the gender gap in terms of life expectancy, observed over many decades, is shrinking slightly, from more than 4 years in 2019 to 3.5 years in 2070. This gap also concerns healthy life years: in 2019, healthy life expectancy is 11.3 years for women and 10.2 for men.

In addition to these estimations, two other trends are of interest: the first one is a slowdown in the gain in life expectancy at birth over the last decade, notably due to three major influenza epidemics from 2014 to 2019, each of which generated around 20,000 registered deaths; the second important issue concerns socioeconomic inequalities in life

[1] All data used in the text come from Annex 1, Background Statistics unless explicitly stated otherwise.

[2] This report does not take into account the impact of the current COVID-19 pandemic which will surely lead to important measures.

expectancy. For example, the difference in life expectancy at birth between the 5% richest and 5% poorest men is 13 years (8 years for women)[3].

Concerning the very old, the share of over-75-year-olds in the French population is growing much more rapidly: from 9.4% in 2019 to 12.5% in 2030 and 16.3% in 2050. In the light of demographic trends, the estimated number of potentially dependent elderly people ("self-perceived longstanding limitation in activities because of health problems, for at least the last 6 months") will grow by 46%, i.e. from 3,018 thousand in 2016 to 4,400 thousand in 2070 (3,433 thousand in 2030 and 4,248 thousand in 2050). According to the 2019 EU Ageing Report, 4.8% of the 65+ population in France received care in institutions, 6.2% at home, and 0.3 received cash benefits, which means that 11.4% of this age group received formal LTC in kind and/or cash benefits.

The French long term care (LTC) system refers to another age threshold, related to the granting of the Personal Autonomy Allowance (APA – *Allocation personnalisée à l'autonomie*) to over 60-year-olds. The estimated number of recipients for this allowance (60+) is likely to increase considerably: from 1,265,000 in 2015 to 1,582,000 in 2030 and 2,235,000 in 2050[4]. Taking into account older people who do not receive the allowance, the DREES estimates that about 1,459,000 people aged over 60 living in the home were subject to loss of autonomy in 2015, in addition to 584,000 people living in care homes, making a total of over 2 million.

1.2 Governance and financial arrangements

Traditionally characterised by a familialist approach to elderly care, with the legal obligation for families to care for their older parents, since the 1990s' France has developed several LTC policy measures and evolved towards a mixed model, combining public measures and family care[5]. LTC policy in France cuts across different policy sectors – health, social and medico-social[6] – and involves several levels of governance: the state, regions, *départements* and municipalities. Regional administrations execute national health policies defined at the central level by the government, whereas the decentralised French local authorities – *départements* – are responsible for social policy. They have a key role in LTC regulation: they define local policy orientations in their territory; finance and manage the national APA; and regulate care services. Though some territorial disparities exist, national regulations remain in social care policy through the definition of the different schemes by national legislation and the follow up of the territorial variations by the government (Libault report, 2019). In addition, municipalities can develop specific voluntary support measures. Along with this territorial organisation, two major institutional actors are involved: the CNSA (national solidarity fund for autonomy – *caisse nationale de solidarité pour l'autonomie)*, created in 2004, which is a national institution responsible for implementing policy measures aimed at older and disabled people[7]; and the ARSs (regional health agencies – *agences régionales de santé*), introduced in 2009. They are the regional

[3] Blanpain, N., 2018. « L'espérance de vie par niveau de vie : chez les hommes, 13 ans d'écart entre les plus aisés et les plus modestes », Insee Première, n°1687, février.

[4] Libault D. (2019), *Grand âge et autonomie* [old age and autonomy], Report commissioned by the ministry of solidarities and health. Downloaded from https://solidarites-sante.gouv.fr/IMG/pdf/rapport_grand_age_autonomie.pdf

[5] Le Bihan B., Da Roit B. and Sopadzhiyan A.,(2019), The turn to optional familialism through the market: Long-term care, cash-for-care, and caregiving policies in Europe, Social Policy and Administration, Special Issue Cash for Care in Europe, p. 579-594

[6] A specifically French sector along with the health and social sectors, whereas common English usage only distinguishes 'health care' and 'social care' sectors.

[7] The funds of the CNSA combined different sources (CNSA, 2019): a transfer of part of the sickness branch of the social security system (€20,4 billion); taxes (€2,7 billion); a social contribution – (€2.4 billion).

representative of central government, extending the regional agencies' traditionally health-sector-only intervention to the social care sector.

The LTC policy involves a wide range of funding (social security system, the *départements*, the CNSA and central government) for wide-ranging expenditure, combining health insurance system and tax-based system for the funding of the APA. In 2016, LTC public spending represented 1,7 % of GDP. Considering national data, and looking to an extended figure including costs covered by households, LTC represents 1.4 of GDP in 2014, and thus constitutes a major, though fragmented, financial investment in France[8]. Concerning the balance between formal and informal care, based on 2011 national data, Bernard Ennuyer argues that the cost of informal care represented almost €15 billion, which added to the concrete cost covered by households (housing, dependency)corresponded to the assessment of the public cost[9].

1.3 Social protection provisions

Different schemes can be distinguished, each with its own characteristics depending on the system (health or social care system) it relies on.

A first group of schemes corresponds to "social assistance schemes" which are managed by *départements* and/or pension funds

- Social assistance for accommodation (*Aide sociale à l'hébergement* – ASH): paid out by the *départements to old people aged 65+ in institutions with low income to complement the part of expenditure for accommodation which cannot be paid by the resident*[10]
- Financial support to pay for home helps: granted by the *départements* and the pensions funds depending on conditions of age and income of old people with the lowest level of dependency.

The corner stone of the social care policy is based on a specific policy measure: the Personal Autonomy Allowance (APA)

Introduced in the late 1990s and focused on situations of 'dependency', the benefit aimed at meeting the needs of elderly people who were not covered by health insurance, by helping them identify their needs and pay for social care services. It was reformed in 2002 and became the APA. Managed by the *départements*, the APA is paid – at home or in institutions – to any person aged 60 or over who needs assistance to accomplish everyday activities or who needs to be continuously watched over. Each level of dependency – according to the AGGIR Grid[11] – gives access to a maximum amount, which is then adjusted according to the recipient's needs and level of income. In 2019, for a GIR 1 the maximum amount of the allowance is €1713; €1375 for GIR 2; €931 for GIR 3 and €662 for GIR 4.

At home, the allowance is paid to finance a specific 'care plan' elaborated by a multidisciplinary team (health and social professionals from the *départements*) after an

[8] Roussel R. (2017), Personnes âgées dépendantes : les dépenses de prise en charge pourraient doubler en part de PIB d'ici à 2060 [dependent elderly people: care expenditure as a share of GDP could double by 2060], Etudes et Résultats, n°1032, DREES. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/er1032.pdf

[9] Ennuyer B. (2017), « Quel avenir pour les personnes dites "âgées" ayant besoin d'aide et de soins dans leur vie quotidienne », *in* Guillemard Anne-Marie & Mascova Elena dir., *Allongement de la vie. Quels défis ? Quelles politiques ?* Paris, La Découverte, p. 279-295

[10].The allowance is delivered to people with an income (houselholds' income + can also include the income of close relatives, depending on the *départements)* below the cost of accomodation. According to the DREES (https://drees.solidarites-sante.gouv.fr/IMG/pdf/16-17.pdf), in 2017, there was 122,000 recipients of the ASH, for an amount of around 870€/month. 92% of the recipients lived alone and 50% of them had an income below 900€/month.

[11] AGGIR Grid distinguishes 6 levels of dependency from GIR1 the Highest to GIR 6, the lowest.

assessment of needs. The use of the benefit is controlled and the multidisciplinary teams are in charge of following up on the situation. The APA represents over €5 billion of expenditure, of which 65% comes from the *département* and 35% from the CNSA (CNSA, 2019). The APA was allocated to 1,285,500 elderly people in December 2016 (7.6% of people aged over 60), of whom 60% in the home and 40% in institutions.

Employing a care worker in the home also opens up the right **to fiscal deductions** and since 2017 **tax credits**.

A final category of schemes concerns informal carers, with two different leaves:
- a carer's leave: allocated for 3 months or a part-time period, renewable up to 1 year. Vote of a financial compensation October 2019 (between €42 and €55 per day from October 2020)
- a family solidarity leave to assist a dying relative: allocated for 3 months, renewable once and be used for a part-time period. Daily allowance of €55 for a max. of 21 days.

1.4 Supply of services

A wide range of services in the social and health care sectors propose solutions for both home care and residential care, as well as supplementary options. They depend on different regulations (related to health or social care systems), which create financial and administrative complexity.

Home care nursing services (*services de soins infirmiers à domicile*, SSIAD) and **Home social and healthcare services** (*services polyvalents d'aide et de soins à domicile*): proposing 125,733 places in 2019 (CNSA, 2019). Health care Services are provided by salaried nurses and auxiliary nurses paid on a fee-for-service basis. Total expenditure on this type of care rose by 2.7% in 2017f, amounting to about € 1.6 billion[12].
Home help and support services (*services d'aide et d'accompagnement à domicile*, SAAD) which constitutes a highly complex sector[13] including non-profit organisations and public social care services requiring quality certification by the *départements*. Based on the analysis of the APA recipients, their number was estimated at 7000.
Private for-profit organisations in the personal services sector, which require specific quality certification. Their prices are established freely. In 2008, they represented only 4% of social care workers for elderly people[14].

Residential homes (*établissements d'hébergement pour personnes âgées dépendantes*, EHPAD): France features 7,438 residential homes (EHPADs), offering 98 places per 1,000 people aged 75 and over[15]. In 2015, these institutions cared for 10% of elderly people aged 75 or more and one-third of those aged 90 or more. The average cost of EHPAD accommodation ranges from €51 to €71 per day[16]. These institutions take different forms (Libault, 2019): private for-profit EHPADs (22% of places), private not-for-profit EHPADs (28% of places) and public EHPADs (50% of places). The latter may or may not be hospitals. Despite an increase in staff-to-patient rates from 2011 to 2015 (from

[12] DREES (2018), Les dépenses de santé en 2017 [health expenditure in 2017]. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/32-7.pdf

[13] El Khomri M. (2019), Plan de mobilisation nationale en faveur de l'attractivité des métiers du grand âge [national plan to make work for the elderly more attractive], Report commissioned by the ministry of solidarities and health. Downloaded from https://solidarites-sante.gouv.fr/IMG/pdf/rapport_el_khomri_-_plan_metiers_du_grand_age.pdf

[14] Marquier, R., (2010), Les intervenants au domicile des personnes fragilisées en 2008 [workers providing support in the home for vulnerable people in 2008], Etudes et Résultats, n° 728 DREES. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/er728-2.pdf

[15] Bazin M. et Muller M., (2018) Le recrutement en EHPAD [recruitment in nursing homes], Etudes et Résultats, N° 1067, DREES. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/er_1067.pdf

[16] Muller M., (2017), 728 000 résidents en établissements d'hébergement pour personnes âgées en 2015. Premiers résultats de l'enquête EHPA 2015 [728,000 residents in old people's homes in 2015], Etudes et Résultats, n°1015 DREES. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/er1015.pdf

59.7 to 62.8 full-time employment (FTE) for 100 places (Bazin et al., 2018), the number of professionals remains insufficient to ensure quality care.

Supplementary options developed between home-based care and institutions:

- **Housing facilities**: concern old people who are mostly autonomous, and propose small apartments adapted to minimise the risk of fall. The development of this type accommodation renamed autonomous residences (*Résidences autonomie)* is a priority of the 2015 ASV Act. They offered 110,000 places in 2018[17].
- Autonomous residences and nursing homes offered 11,900 **day care places** and 15,500 in **temporary accommodation** in 2018 (CNSA, 2019).

In 2015, 728,000 elderly people lived in residential care, an increase of 4.8% compared with 2011 (Muller et al. 2017). The recent Capacités, Aides et Ressources des seniors (CARE) survey[18] estimates the number as being between 0.4 million (including only high-level dependency cases) and 1.5 million (also including mid-level dependency cases). Concerning the balance between formal and informal carers, the CARE survey established that almost 50% of the elderly in need of care receive support from their relatives and 20% only professional support. A third get both formal and informal support[19].

2 Assessment of the long-term care challenges in the country

2.1 Access and affordability

In France, 4.8% of the over-65s were cared for in institutions compared to 6.2 in their homes. Out-of-pocket spending varies according to whether care is provided at home or in an institution, as well as according to the level of dependency of the elderly people concerned. One month's accommodation in an EHPAD for a person with a radical loss of autonomy costs on average €2,450[20] with on average €1,850 remaining to be paid by the user (after allowances and tax reduction) (Libault, 2019). While the APA covers 100% of healthcare costs and about two-thirds of "dependency" costs, accommodation services are the responsibility of families (except very low income; see Section 1.3).

The question of cost is more difficult to value in the home. Depending on the income of the old person, the remainder to be paid can range from €2,500 to €4,050 in highly dependent situations, when a permanent presence is required (Mutualité Française, 2018). However, these figures should be viewed differently for old people benefiting from support from an informal carer in their homes. According to DREES data, the remainder to be paid in this case depends on the level of dependency, and ranges from €117 for a high level of dependency (GIR 1) to €37 for an average level (GIR 4). This explains the average figure of €60 remaining to be paid by old dependent people (after allowances and tax reduction) presented in the Libault Report. While this amount may seem acceptable, it raises the question of the significant share of invisible, unpaid work carried out by informal carers to enable this lower financial cost through maintenance in the home.

Fragmentation is a main characteristic of the French LTC field, with the separation between health care and social care sectors. Improving the coordination of organisations,

[17] CNSA (2019), Les chiffres clés de l'aide à l'autonomie 2019 [key figures on support for autonomy], CNSA.

[18] Brunel M., and Carrère A., (2017), Les personnes âgées dépendantes vivant à domicile en 2015. Premiers résultats de l'enquête CARE 'ménages' [dependent old people living at home in 2015], Etudes et Résultats, n°1029, DREES. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/er_1029.pdf

[19] Brunel M., Latournelle J. and Zakri M., (2019), Un senior à domicile sur cinq aidé régulièrement pour les tâches du quotidien, [one old person in five living at home receives regular support for everyday tasks], Etudes et résultats, n° 1103, DREES. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/er1103.pdf

[20] Mutualité Française [French Mutuality], (2018),Santé, perte d'autonomie: Impact financier du vieillessement [Health and loss of autonomy: Financial Impact of Ageing]. Place de la Santé. L'observatoire. Downloaded from https://www.accueil-temporaire.com/sites/default/files/public/actualite/2018-10_barometre-fnmf-1018_vf_180926.pdf

institutions and professionals in order to facilitate the access and affordability of services and schemes has been high on the political agenda during the last decade. Since 2010, three different schemes have been developed with the objective of facilitating relations between the different actors at the local level: the MAIA *(Méthode d'Action pour l'Intégration des services d'aide et de soin dans le champ de l'Autonomie*- action for integrated health and support services in the autonomy field*),* introduced in 2010 and concerning 60+ elderly people with complex needs; the PAERPA *(Personne Agée En Risque de Perte d'Autonomie* - old people at risk of losing their independence), created in 2014, which is a specific health pathway combining a range of tools in a prevention perspective targeting elderly people aged 75+; the PTA (*Plateforme territoriale d'appui*- territorial support platform), which is not population-based, and more recently the DAC (*Dispositif d'Appui à la Coordination* – coordination support measure), which aims at gathering all of these existing schemes into one (see Section 3).

2.2 Quality

In France, no formal, comprehensive definition of LTC quality has been produced by national or local public authorities. Nevertheless, the Act of 2 January 2002 reforming social care sector describes the different components of quality. Taking into account recent evolutions (ASV Act), three main dimensions can be identified:

(1) The obligation for social care institutions to carry out a double evaluation: internal evaluation carried out by the institution and focused on quality improvement propositions; and external evaluation (which guarantees renewed authorisation) carried out by an external body approved by the National Authority for Health (HAS)[21], and which concerns their activities and the quality of the services they deliver.
(2) The respect of different basic user rights: respect for dignity, integrity, private life, intimacy and security; free choice between services at home or in institution; personalised, quality care and support that respects informed consent; confidentiality of user data; access to information; direct participation in the definition of the "care and support project" – as well as tools enabling the exercise of these rights: the existence of a welcome booklet; respect for the charter of rights and freedoms of the person hosted; recognition of a qualified individual; visible operating regulations of the establishment or service; the existence of a "community life council" which encourages user participation; and the production of an establishment or service project.
(3) Multiannual contracts (5 years) of objectives and means (CPOM) – which were made general to all social care facilities by the 2015 ASV Act - are signed between social care institutions and pricing authorities (*ARS* and *départements*).

The double evaluation process was questioned in a recent report[22] which identified different elements for improving quality approach: a better articulation between the two evaluations, a harmonization of the external bodies which produce evaluation and a standardization of the different indicators used for the evaluation.

This issue is related to the employment issue and the very low appeal of the LTC labour sector. Recent solutions were proposed by the Libault report (see box 1); for example, creating indicators to measure the quality of services available in residential homes.

[21] Created in 2009, the French National agency for evaluating the quality of social care institution and services (ANESM) is now included in the National authority for health (HAS).

[22] Vidal A. (2018), *Rapport d'information sur l'évolution de la démarche qualité au sein des EHPAD et de son dispositif d'évaluation [information report on the evolution of quality in residential care]*, Assemblée nationale, n° 1214.

2.3 Employment (workforce and informal carers)

It is difficult to estimate the number of professionals working with elderly people – both health professionals (nurses and assistant nurses) and social care workers (also called personal carers) – because no statistics precisely list professionals in this highly fragmented labour sector. In 2016 France had 2.3 LTC workers for 100 people aged 65+, (91% of these LTC workers are women). In terms of national data, the Libault Report - which raises LTC workforce as a key issue of the French LTC policy (see box 1) – makes the following estimate for 2018: about 830,000 FTEs work with dependent elderly people, including 430,000 FTEs in institutions, 270,000 FTEs in home social care services, and 130,000 in home health care services.

Qualification is a key issue concerning LTC workforce. As recalled in a recent OECD report[23], in France qualifications are required for nurses (specific training after bachelor's degree), and there is the possibility for personal workers to obtain a specific diploma (created in 2002).Continuing training programs were also developed. In spite of this, the LTC care work sector remains unattractive[24]. The OECD report underlines the difficult working conditions of LTC workers, with France having the highest shares of LTC workers reporting accidents and work-related health problems. The difference between LTC workers and hospital workers is also highlighted, with the first category earning less than the second one. The average wage of home carers is €832 per month, but monthly earnings vary significantly according to whether care workers are employed full time (€1,190) or part time (€717), and whether the structure they belong to is public or private[25]. Employment situation is another main issue. LTC workers work in shifts and work during weekends. The employment stability given by the existence of permanent contracts is only apparent because of the high prevalence of part-time work: 23% of nurses, 31% of personal carers and 42% of LTC workers holding a part time position at home (26% in institutions) (OECD, 2019). Besides, the employment of a great proportion of temporary agency workers in institutions can also be underlined (OECD, 2019).

Finally, it should be noted that the specific social care work sector developed in France to provide personal care (as a complement to the health care delivered by nurses and assistant nurses) in the home is part of the larger sector of 'personal services' (*services à la personne*), which includes any person providing services to individuals. Focusing on the volume of workers in order to reduce unemployment, it is not always matched by quality (Le Bihan et al.2018).

In France, a large majority of elderly people currently receive informal support from families and friends – 21% of the 60+ population, representing 3 million elderly people (Brunel et al., 2019). 10,2% of the population provide informal care, with 12,2% women and 8,1% men. According to national statistics, 3.9 million informal carers[26] perform a great variety of concrete tasks (ADL provision, meal preparation, personal care, etc.) and coordinate activities. Evidence shows that informal carers carry out more diverse tasks than professional care workers, who focus on instrumental tasks (Brunel et al. 2019). A recent survey (Besnard et al. 2019) shows that half of these carers are children, and a quarter are spouses or partners. Aged on average 73 for the latter and 52.2 for the former,

[23] OECD (2019), *Ensuring an Adequate LTC workforce*.

[24] Le Bihan B., and Sopadzhiyan A., (2018), 'The development of an ambiguous care work sector in France. Between professionalization and fragmentation', in Christensen K. and Pilling P. (eds), The Routledge Handbook of Social Care around the World, Routledge, p. 102-115.

[25] Nahon, S., (2014), Les salaires dans le secteur social et médico-social en 2011. Une comparaison entre les secteurs privé et public [pay in the social and medico-social sector in 2011 - comparison between private and public sectors], Etudes et Résultats, n°879 DREES. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/er879.pdf

[26] Besnard X., Brunel M., Couvert N. et Roy D., (2019), Les proches aidants des seniors et leur ressenti sur l'aide apportée, résultats des enquêtes CARE auprès des aidants (2015-2016) [family caregivers of the elderly and their experience of support, results of CARE surveys of carers] Les dossiers de la DREES, n°45. Downloaded from https://drees.solidarites-sante.gouv.fr/IMG/pdf/dd45.pdf

most of them are women (59.9%). Four carers in ten are in employment. Considering the increase in the labour market participation of women aged 50 to 64[27], the issue of work-life balance is particularly acute for women.

In France, public intervention aimed at informal carers is based on "supportive measures" defined as measures to assist carers in their role[28]: alongside the existing training available since the 2009 Health Law and the national web platform created in 2013, the 2015 ASV Act has introduced a right to respite, and created special centres for the elderly and their carers (see Section 3). Until recently, financial measures aimed at compensating informal carers remained marginal with the possibility to use the APA to pay a relative (except the spouse), (8% only of APA beneficiaries pay a relative as their home carers[29]; the recent vote of a financial compensation to pay the existing carer's leave marks a turning point in the type of measures implemented (see Section 3).

2.4 Financial sustainability

Different factors can be identified to analyse the financial sustainability of LTC policy. One component is the demographic determinant (see Section 1.1). However, expenditure also varies according to the level and type of coverage of the needs of the population; in particular whether France relies on formal or informal care, at home or in institutions[30].

According to data from the Economic Policy Committee (EPC) Working Group on Ageing Populations and Sustainability (AWG), public expenditure on LTC is projected to increase in France by 0.8 GDP percentage points (or 46%) between 2016 and 2070 (from 1.7 in 2016 to 2.5 in 2070) in the "demographic" scenario, based on the impact of an ageing population on public LTC expenditure (0.5 pp below the EU27 level of increase at 1.3). This increase still varies according to different demographic calculations: from 0.6 in the healthy ageing scenario to 1.1 in the high life expectancy scenario.

Nevertheless, these projections depend on different policy-change options. The EPC's Working Group on Ageing considers a variety of scenarios: a "shift from informal to formal care" scenario, which considers a shift to formal care to progressively replace the informal care and cash-for-care option (the change between 2016 and 2070 is estimated at 1,3 percentage point or an increase of 76%). EPC working group also consider a "AWG risk" scenario, which is based on the assumption that half of the future gains in life expectancy are spent with no care-demanding disability as in the reference scenario. In this scenario public expenditure on LTC will grow from 1.7 in 2016 to 4.5% of GDP in 2070, which means a 2.8 percentage points of difference or a growth by 160%.

By breaking down the impact of drivers on the difference in spending growth (2016-2060) and taking into account the real change between the 2015 and 2018 ageing reports, EPC establishes a relatively stable situation for France, with a zero base-year effect, which represents the difference between the variation in spending between the 2018 and 2015 ageing reports and the sum of the different sources of change, including those linked to methodology and policy reforms.

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[27] Up to up to 61.2% in 2017 according to INSEE, (2019), Les tableaux de l'économie française [French economy tables], INSEE.

[28] Le Bihan B. Lamura G., Marczak J., Fernandez J.L, Johansson L. and Sowa-Kofta A., (2019), Policy measures to support unpaid care across Europe, in Enhancing the sustainability of Long Term Care, Eurohealth, vol 25/4, p. 10-14.

[29] Court of Auditors (2016), Le maintien à domicile des personnes âgées en perte d'autonomie [Maintaining old dependent people in their homes], Court of Auditor report, downloaded from https://www.ccomptes.fr/sites/default/files/EzPublish/20160712-maintien-domicile-personnes-agees.pdf

[30] These elements generally appear in terms of level of coverage of the "potentially dependent population" in terms of access to home care, institutional care and cash benefits. The potentially dependent population refers to EU-SILC data on "self-perceived longstanding limitation in activities because of health problems [for at least the last 6 months]" (EU 2018 Ageing Report, op cit.).

National analyses on the cost of dependency have also been produced. Roussel (2017) estimates LTC costs at €30 billion in 2014 (1.4 point of GDP), which comprises €23.7 billion public expenditure (79% of the total) and €6.3 billion covered by households. Expenditure is split as follows: €12.2 billion devoted to healthcare expenditure (€12.1 billion public funding, €0,1 billion by households); €10.5 billion devoted to coverage of loss of autonomy (€8.3 billion public funding); €7.1 billion devoted to institutional accommodation (including €3.1 billion public expenditure and €3.8 billion by households). To this can be added €4.4 billion for "board and lodging" (the cost of food, housing, and insurance paid for by households in institutions that they would have to cover in the home). However, this figure does not include the cost of informal care which is evaluated at between €7 billion and €18 billion. As argued by several studies, the expenditure related to the elderly care is in fact equally shared between households and public sector. Based on these data, the Libault Report calls for a necessary 35% increase in the share of national wealth devoted to the loss of autonomy, which corresponds to public expenditure of about 1.6% of GDP. A specific funding plan is proposed in the report (see box 1).

2.5 Country-specific challenges regarding LTC for other age groups in need of care

Specific key challenges can be identified regarding care for children and disabled people. An important issue arises from the policy to facilitate inclusion for disabled people in a "normal environment"[31]. This "inclusive turn or shift", which involves reducing institutionalisation, implies the development of suitable conditions in the so-called "normal environment". It concerns both encouraging employment of disabled people in public and private sectors and facilitating schooling for children with disabilities. In this perspective, the professionalisation of special needs assistants who support children at school every day is a key dimension of this policy orientation. The shift was initiated in 2013 with the introduction of a professional status - assistants for pupils with disabilities (*Accompagnants des élèves en situation de handicap* – AESH) requiring a higher level of education to be selected (at least *baccalauréat* or equivalent) and receive specific training. The professionalisation was then pursued with the creation of a state educational and social assistance diploma (*Diplôme d'Etat d'Accompagnement Educatif et Social* – DEAES). Another important step is the establishment of a personalised plan for each child included in a specialised unit (ULIS – *Unité localisée pour l'inclusion scolaire*, local unit for inclusion in schools) which is linked to an "ordinary" school. Another issue in the field of LTC care concerns the reform of the pricing of institutions and medico-social services working with disabled people. This vast project was initiated in 2015 and is still underway.

3 Reform objective and trends

The major guidelines of a deep-seated reform were presented in a report dating from March 2019 – the Libault Report (see box 1). Initially announced for 2019, the Old Age and Autonomy Plan was delayed. Yet, in the context of the COVID-19 crisis and considering the strong impact on elderly people at home and in institutions[32], it was confirmed as a policy priority in May 2020.

It is also worth noting the special attention paid to **family caregivers** in 2019**:**

- The Act of 22 May 2019 aimed at facilitating taking leave and securing carers' rights.

[31] This expression "environnement ordinaire" means inclusion of disabled people in all sectors and activities.

[32] The current COVID-19 pandemic has dramatically impacted the older-old population. In April 2020, more than 25,000 people in nursing homes (EHPAD) had been infected by Covid-19 in France and more than 8,000 deaths had been registered in nursing homes. The mortality rate due to Covid-19 is closely linked to age and gender. 50% of patients with Covid-19 admitted into intensive care were aged 65 or over and 60% of them were men.

- The vote in October 2019 of an allowance for recipients of the carer's leave which aims at encouraging carers to make use of the leave that was in little use at that point[33].
- A national strategy to encourage support for carers (see box 1).

In addition, there was a specific measure with a view to **improve quality, along with access and affordability**: the Act of 24 July 2019 on the transformation of the health system, establishing the integration of existing coordination measures into complex pathways (MAIA, PTA, PAERPA, networks) within a unique support measure (DAC).

The ASV Act (implemented in January 2016) is the latest general reform to date. While criticised for the insufficient financial resources it opened up[34], it has led to steps forward:

Concerning **access and affordability**, it is worth mentioning measures to upscale the APA and reduce the number of people subject to co-payment. The ASV Act has thus led to a +6.5% increase in APA expenditure (Libault, 2019). It also highlighted prevention and coordination, with the introduction of a special body – the funders' conference to prevent elderly people's loss of autonomy – to manage coordination at the *départements* level.

Concerning **informal care**, the ASV Act has had a real impact: the proposal of a formal definition of carers including friends and neighbours; the introduction of the right to respite (with financial support of up to €500 per year), and the creation of special centres for the elderly and their carers (*Maisons des aînés et des aidants*), a kind of one-stop shop that provides information, administrative support for users, and also support to organise the coordination of social and health care responses.

Concerning **quality,** the ASV Act made multiannual contracts (CPOM) general to regulate all social care facilities.

Box 1: Planned reforms and on-going legislative process and debates

The 2019 Libault Report

While maintaining older people in their homes and increasing freedom of choice in the organisation of care are put forward as priorities, the 175 measures presented in the Report concern both the development of quality support in the home and care in institutions[35]. Concretely, three main strands can be identified:

The first of these consists of a series of measures aimed at reorganising the various types of existing financial support, which include: creating a new home-based cash benefit (to replace the current APA with three components: personal assistance, technical support and respite (for carers)); merging healthcare and social care expenditure in residential homes to reduce the remaining amount which is payable by residents.

The second strand concerns the development of services in the home and in residential homes through: renovating residential homes and making them more open to the outside world(a renovation plan worth €3 billion has been announced); increasing the supervision rate in residential homes by 25%, by recruiting 80,000 employees at an estimated cost of €1.2 billion; creating 60,000 places in residential homes; developing alternatives to residential homes or home-based care, i.e. temporary accommodation and collective housing; creating indicators to measure the quality of services available in residential homes.

Finally, the third strand aims to increase support to the 3.9 million informal carers who provide care to older relatives. This will be done by simplifying procedures and access to information, providing financial aid to support informal carers, and facilitating informal carers' work/life balance.

[33] Sirven, N., Naiditch, M., and Fontaine, R., (2015), Etre aidant et travailler, premiers résultats d'une enquête pilote [combining caregiving and working, first results of our pilot survey], Université Paris-Descartes. Downloaded from http://www.aveclesaidants.fr/wp-content/uploads/2015/12/RapportFinalMACIF-JNA-2015.pdf

[34] Le Bihan B., (2016), France anticipates ageing society through new piece of legislation, European social policy network, ESPN Flash report 2016/18.

[35] Le Bihan B., and Sopadzhiyan A., (2019), Future trends in French LTC Policy: the Libault Report, European social policy network, ESPN Flash Report, 2019/25.

The set of measures announced in the report will require massive public funding with an estimated additional amount of €9.2 billion by 2030. The Report argues in favour of financing LTC policy through national solidarity, by recognising "loss of autonomy" as a genuine social protection risk, and including this in social security funding legislation. The favoured scenario is that an existing pay deduction (the Contribution to Reducing the Social Debt [CRDS]), which will have been fully paid by 2024, will be converted into funding for loss of autonomy. Recourse to private funding is presented as additional to public funding. One possibility could be to take account of a share of property assets when calculating the level of the benefit received, in order to support funding of home-based and residential care. Alternative scenarios, such as creating new mandatory pay deductions, or extending working time by cancelling a national holiday, have so far been ruled out. Besides this financing challenge, the governance of LTC policy needs to be clarified, as it involves two main institutional actors – regional health agencies and local councils – who can have a tense relationship[36].

Two documents have been produced in 2019 to confirm the chosen direction: the El Khomri report, which outlines measures and steps for the reorganisation of the LTC workforce; and the National strategy for mobilisation and support to carers which concerns all carers (whatever the age of the cared-for). Following in the vein of the ASV Act and the Libault Report, it stresses the need to open up new rights for carers and anticipate their exhaustion and isolation, and to diversify and increase the reception capacities of respite places.

4 Main opportunities for addressing LTC challenges

The announcement of a comprehensive Old age and Loss of Autonomy Plan, based on the Libault Report, is the next step awaited by all professional and institutional actors. Confirmed as a priority by the impact of the COVID 19 crisis, it represents main opportunities for addressing LTC challenges in relation with demographic evolutions:

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- The recognition of "loss of autonomy" as a genuine social protection right, with its inclusion in social security funding legislation and the confirmation of the €9.2 billion by 2030.
- The reorganisation of the LTC workforce at home with a a reform of the complex pricing system; and an improvement in working conditions for care workers to make the sector more attractive
- The recruitment of qualified and recognised health and social care professionnals in institutions.
- Further development of coordination efforts in order to simplify the existing schemes, avoid fragmentation or overlapping measures and facilitate continuity of care for the old person.
- Building on what has already been done in terms of compensation, conciliation or supportive measures for informal carers, the development of policy measures to support informal care combined with the improvement of services at home and in institutions in order to enlarge choice for informal carers.
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[36] Le Bihan B. and Sopadzhiyan A., (2017), The development of integration in the elderly care sector: a qualitative analysis of national policies and local initiatives in France and Sweden, Ageing and Society, Published online by Cambridge University Press: 26 December 2017, pp. 1022-1049 Print publication: May 2019 doi:10.1017/S0144686X17001350

Annex 1 Background statistics

Annex 2 National statistics

Loss of autonomy for elderly people are measured in the following ways:

- By adding up the number of people targeted by the public measures that concern them (APA). “Dependent” people are considered to be those who come under GIR 1 to 4. The GIR ranking is determined by a team of professionals from the health and social care sectors who visit the old person at home to assess his/her level of dependency and needs (there are 6 levels of GIR from the highest, GIR 1 to the lowest GIR 6). Although relatively limited, this conventional definition of loss of autonomy has the advantage of corresponding to the eligibility criteria for the Personal Autonomy Allowance (APA). This definition, on which many statistics are elaborated in France, is limited because it uses an administrative definition of loss of autonomy and consequently excludes people who do not claim the benefit even though they might need it.
- By evaluating people’s functional status through tests. This measure has the advantage of being more reliable, but it is difficult to implement as part of a statistical survey on a broad cross-section of people.
- Lastly, by directly questioning people about the difficulties that they come up against, covering a broad range of people to ensure that the results represent the entire group. This is the approach taken by the Handicap-Santé (2008) and CARE-Ménages (2015) surveys by carried out by the DREES which is referred to in this report.

Source: https://solidarites-sante.gouv.fr/affaires-sociales/personnes-agees/concertation-grand-age-et-autonomie/article/rapport-de-la-concertation-grand-age-et-autonomie