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INSTITUT NATIONAL D'ÉTUDES DÉMOGRAPHIQUES

Long-term care in France

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ANÁLISIS COMPARADO DE LOS SISTEMAS DE PROTECCIÓN A LA DEPENDENCIA EN EUROPA. LA REFORMA DE LA LAPAD EN ESPAÑA.

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Defining LTC

What is LTC?

- Long-term care?
- A specific policy or an economic sector (providers)?
- Care instrument for a specific population or specific needs?
- Is it define by the lenght of the care need ?

→ We all talk about LTC without necessarily talking about the same thing.

  → Germany will take an inclusive political approach and LTC will cover disability and dependency in compensation schemes (as in Spain) but also prevention and rehabilitation.

  → But Quebec or New-brunswick in Canada explicitly develop two policy instrument and will in most of the case speak only about elderly needs.

In France LTC is not translated

- If we translate it, it correspond to a tiny part of the care system. That of "rehabilitation centres". We will talk about "long-term care units".
- These are temporary accommodation facilities representing:
  - →32,000 places out of 770,000 places in establishments for elderly people
  - →The staff-to-resident ratio is 103%, compared to 62% in nursing homes

Introductory remarks:

LTC needs is also structure by external factors

"The dependency of elderly people, or to refer to a concept used in a number of European countries, long-term care, is a major challenge for social protection systems. It raises multiple problems – demographic, economic, social and political – in all European countries. » (Le Bihan, 2013)

- The demographic ageing process raises the crucial question of **longer life expectancy with disabilities** (staying at home is now the preferred option), but also, as a consequence, that of **family carers**.

✓ Some analyses (Gaymu *et al.*, 2008) show that the number of family carers will not necessarily decrease

✓ However, the question of their availability arises. Several societal changes are leading to a significant risk of *a* "*care deficit*".

- Geographical mobility, which leads to families being scattered across the country.
- The increase in women's participation in the labour market...
- The postponement of the retirement age…

➢ These challenges of work-life balance are leading public authorities to develop support mechanisms not only for elderly people who are losing their independence, but also for their relatives.

LTC policy as an economic issue

- The political response to the care needs of older people and their families is also an economic issue

- ✓ **Financing dependency**: in a context of severe budgetary constraints, the cost of caring for elderly people who have lost their independence is a major challenge.
  - Numerous analyses highlight the inevitable increase in the share of GDP linked to dependency in the coming years – in France, it is expected to rise from 1.2% in 2010 to 1.76% in 2040
  - Different countries have different care systems: the Bismarckian insurance system based on work; the Beveridge welfare system based on taxation; and an hybrid system in France.

- ✓ **Dependency as a wealth-creating sector**: the issue of employment.

  In France, while the primary objective of creating a specific system for caring for dependent elderly people is to meet the needs of users, it is also to develop the personal services sector with a view to reducing unemployment.

From dependence among the elderly to policies promoting autonomy

History of policies on ageing in France

Alain Grand, offers an analysis of this policy on ageing in France, divided into three periods:

1. **From 1962 to 1980 (i.e. since the Laroque report), there has been a fight against the precariousness of old age and the introduction of a policy of home support, in a context of strong economic growth.**

Numerous measures were put in place from the 1970s onwards, focusing on:

- ✓ the social integration of care facilities,
- ✓ home care and adapting the home environment.

- The law of 31 December 1970, which made hospitals the cornerstone of the healthcare system, now excluded the care of elderly and disabled people from their remit => Hospitals became places of cure rather than places of shelter.
- The Social Act of 1975 provided for the creation of social and medico-social establishments for the care of the elderly (transformation over 10 years of hospices into retirement homes or long-stay facilities for dependent persons) => Separation of health and social care.
- A circular dated 28 January 1977 entitled "Promoting home care for the elderly" accelerated the development of home help services for retirees at home.

History of policies on ageing in France

2. From 1980 to 2000, diversification of supply and decentralisation, in a context of slower economic growth and social budget deficits.

- ✓ Creation in 1981 of home care services for the elderly to prevent or delay admission to hospital or institutions => Provision of nursing and hygiene care to dependent elderly people and people under 60 with disabling conditions.

- ✓ At the same time, there was a challenge in terms of employment, in a context of rising unemployment.
  - In 1987, intermediary associations were recognised, with the dual objective of integrating people in difficulty and developing new services.
  - In 1987, the first taxe exemptions for private employer for home care for elderly people (over 70) and disabled people.
  - In 1991, the law on family employment and the Service Employment Cheque (CES) for direct (private) employment.
  - In 1996, these benefits and exemptions were extended and companies were given the opportunity to offer services.

- ✓ 1995: Experimental dependency benefit in 12 experimental departments.

- ✓ Law of 1997 => introduction of the PSD (specific dependency benefit) on a temporary basis prior to the planned introduction of an autonomy benefit. It is coverable on inheritance. In particular, it introduced the AGGIR grid, which determines the level of allowance.

History of policies on ageing in France

❑ **From 2000 to the present day –** a context of near economic stagnation and increasing social debt

✓ **Implementation of the personalised autonomy allowance (APA),** paid by the departmental councils => Rather than creating a 5^{e} risk of national social protection.

- The law of 20 July 2001 thus stipulates that "*any elderly person residing in France who is unable to cope with the consequences of a lack or loss of autonomy due to their physical or mental condition is entitled to a personalised autonomy allowance enabling them to receive care tailored to their needs*".
- This period was marked by a economic liberal approach, with control of public spending and stimulation of the personal services market (Borloo plan on personal services) and a reorganisation of procedures for service providers.
- The National Solidarity Fund for Autonomy (CNSA) was created on 1 January 2006 and partly finances the APA.

✓ **Strengthening coordination of care pathways and combating social and regional inequalities**

✓ Affirmation of rights related to loss of autonomy, in particular the law on adaptation to ageing (2015), **which increases the amounts of the APA and recognises the status of family carers**

✓ **Semantic shift from dependency policies to autonomy policies**

Autonomy as political change

policy transformation

- alignment with disability policies, merge of administrations and coordination services

alignment with professionals

- Exchange of practices / reappropriation, but new form of distinction

distinct instrument

- Maintaining separate instruments for the two audiences. Needs related to disability are considered to be more specific and varied.

Autonomy Policies today

Focus on policies to support elderly people and loss of autonomy

Social assistance for the elderly

❑ **Social assistance as defined by law**

Social assistance for elderly persons is defined by the Social Action and Families Code (CASF): "*Any person aged 65 or over who lacks sufficient resources may receive either home help or placement with private individuals or in an institution. Persons over the age of 60 may obtain the same benefits when they are recognised as unfit for work.*"

❑ **The department: leader in social action** (decentralisation):

✓ The law of 22 July 1983 first gave departments jurisdiction over legal social assistance under common law. It is responsible for defining and implementing social action policy: developing the departmental plan for social and medico-social organisation, authorising and financing local information and coordination centres (CLICs).

✓ Furthermore, in the field of social intervention for the elderly, the APA, which came into force on 1 January 2002, broadens the responsibilities of the departments. It is accessible to a wider audience than the specific dependency benefit (PSD), which it replaces.

✓ Departments must comply with a number of legislative provisions on the amounts and conditions for granting the various benefits. However, departments have a certain amount of leeway, since Article L. 121-4 of the CASF specifies that "*the departmental council may decide on conditions and amounts that are more favourable than those provided for by the laws and regulations applicable to [social assistance] benefits. The department shall bear the financial cost of these decisions*."

Departmental assistance for the elderly

- **Direct assistance to individuals:**
  - **Mainly**:
    - social housing assistance (ASH),
    - domestic help and family care
    - personalised autonomy allowance (APA).
    - NB: The disability compensation benefit (PCH) is also available to elderly people who have lost their independence, provided they were already receiving this benefit – or were eligible for it – before reaching the age of 60.
  - **Recoverable assistance**
    - By definition, social assistance expenses are recoverable by departmental councils – at least in part – from the beneficiaries' dependents and through recourse to their estate (Articles L. 132-6 and L. 132-8 of the CASF3).
    - However, this rule has been relaxed, since currently only social assistance for accommodation (ASH), accommodation by private individuals for a fee and domestic care give rise to such recoveries. APA, on the other hand, is completely exempt.
    - In other cases, recovery from the estate is partially implemented.
- **Also providing coordinnation administration on their territorry**

The role of other actors in assisting the elderly

- **The role of other local authorities**
  - ✓ Other local authorities, especially municipalities and their public institutions, also play an important role.
    - ✓ They provide a reception and information desk
    - ✓ They can offer direct services (home help, facilities, remote alarms, etc.)
    - ✓ They can offer preventive activities (physical activities, support for associations)
    - ✓ They can offer general social services (visits, Christmas hampers, etc.)
- **The role of the State with regard to dependency – the ARS**
  - ✓ They are responsible for the regional management of the health system. They define and implement health policy in the region, in line with the needs of the population.
  - ✓ Steering public health policy (prevention, health monitoring and safety) in the region and regulating the provision of care in both hospitals and private practices.
  - ✓ Funding health services such nursing services at home and nursing care in nursing home.
  - ✓ Co-funding initiatives with departments on calls for tender.

  → We can agree with Lafore (2013) that "*the impact of the creation of ARSs (2010), with the inclusion of medico-social services in their remit, is disrupting social action: the medico-social framework, established at regional level and built with reference to the regional health plan, is unlikely to be consistent with the approaches of several departments that are legally required to be involved*".
- **The role of social security pension fund in prevention**

The personalised autonomy allowance (APA)

- Established by the Act of 20 July 2001 on the care of loss of autonomy in elderly persons and the personalised autonomy allowance. This law stipulates that "*any elderly person residing in France who is unable to cope with the consequences of loss of autonomy linked to their physical or mental condition is entitled to a personalised autonomy allowance personalised autonomy allowance enabling care adapted to their needs*".

- The amount of the APA depends on the degree of dependency and the resources of the elderly person. With reference to the 2002 Finance Act, the APA is not subject to recovery from inheritance or maintenance obligations, nor is it subject to income tax.

- The conditions for entitlement to the APA
  - ✓ be at least 60 years of age
  - ✓ reside in France and provide proof of stable and regular residence
  - ✓ be French or a foreign national legally residing in France
  - ✓ have a certain level of dependency corresponding to a loss of autonomy in class 1 to 4 of the AGGIR grid.

- Assessment of dependency

The degree of dependency is assessed by a medical-social team comprising at least one doctor and one social worker, either at the time of the initial application or during subsequent reviews, either at home or in a residential care home for dependent elderly people (EHPAD).

Personalised Autonomy Allowance (APA)

- ❑ The AGGIR grid (Autonomy Gerontology Resource Group).
- ✓ This assessment grid allows the degrees of dependency to be divided into 6 groups called GIR (Resource Iso Group), which is the reference for the APA.
- ✓ There are 6 GIR groups:
  - group 1 = the highest level of dependency, i.e. people who have lost their mental, physical, locomotive and social autonomy and require the constant presence of carers
  - group 6 = includes elderly people who have not lost their independence in terms of everyday activities
  - Only the first four GIR groups are eligible for APA. Elderly people in groups 5 and 6 are not eligible for APA, but may nevertheless receive home help services through their pension scheme (basic and supplementary) or through departmental social assistance.
- ✓ The degree of loss of autonomy is measured according to 17 variables:
  - so-called "discriminating" variables, i.e. those relating to the loss of physical and psychological autonomy, which are used to calculate the GIR (e.g. coherence, orientation, washing, dressing, elimination, transfer, movement, communication, etc.)
  - illustrative variables, concerning the loss of domestic and social autonomy. These are not included in the care plan (leisure, cooking, etc.).

Personalised autonomy allowance for Autonomy (APA)

- Two way for one intrument:
- ✓ **APA at home** for people living in ordinary housing or in independent living facilities:
  - assistance in kind covering part of the costs resulting from a care plan established by a medical-social team.
  - The amounts of the care plans are capped, with the cap depending on the beneficiary's GIR.
  - The majority of payments are used to pay for home care, but they can also be used to pay for temporary accommodation or day care, technical aids or home adaptations for the beneficiary.
- ✓ **The APA in residential care homes** for the elderly is then used to cover part of the "dependency" fee charged to residents (« cure » fee are cover by social security, housing fee can be partly cover by ASH)
- NB**: The law of 28 December 2015 on adapting society to ageing** changed the amounts allocated for APA at home.
  - ✓ The financial ceilings for assistance plans have been raised from €100 to €400 per month, depending on the GIR.
  - ✓ The amount of the co-payment (i.e. the portion of the support plan that the beneficiary must pay) now depends not only on income, but also on the amount of the support plan.
  - ✓ A right to respite for family carers have been intrduced.

Overview of social assistance expenditure

- In 2018, 1.3 million people aged 60 and over (7.6%) received APA, including more than 540,000 in institutions (41%).
- Total APA expenditure amounted to €5.6 billion. The average annual expenditure per beneficiary was €4,450.
- For all forms of assistance, expenditure amounted to €7.3 billion for 1.45 million beneficiaries, representing an average expenditure of €420 per month per beneficiary.
- Benefits are mainly structured around a financial instrument, the APA, for €6 billion.
- 25% of 85-90 year olds receive APA, 50% of 90+ year olds

Tableau 1 **Nombre de prestations d'aide sociale aux personnes âgées et dépenses associées, en 2017 et 2018**

	Nombre d'aides au mois de décembre (en milliers)			Dépenses annuelles, en milliers d'euros courants, évolution en euros constants			Dépenses brutes mensuelles moyen par aide sociale départementale
	2017	2018	Évolution 2017/2018	2017	2018	Évolution 2017/2018	2018
Aides à domicile	**787**	**794**	**0,8**	**3 557**	**3 596**	**-0,7**	**380**
dont aides ménagères	18	17	-3,9	81	58	-28,8	280
dont APA[1]	769	777	1,0	3 477	3 538	-0,7	380
Aides à l'accueil	**666**	**672**	**0,9**	**3 724**	**3 733**	**-1,6**	**470**
dont aide sociale à l'hébergement (ASH)[2]	122	122	0,1	1 273	1 262	-2,7	860
dont accueil chez des particuliers	3	2	-15,6	19	19	-3,0	650
dont APA[1]	541	547	1,2	2 431	2 452	-1,0	380
Total aides à domicile et à l'accueil	**1 453**	**1 465**	**0,9**	**7 281**	**7 329**	**-2,3**	**420**
dont APA[1]	1 310	1 324	1,0	5 942	6 024	-0,5	380
Autres aides	-	-	-	**325**	**368**	**11,3**	**ND**
Total	**ND**	**ND**	**ND**	**7 606**	**7 697**	**-0,6**	**ND**

ND : non disponible.
1. Pour l'APA, sont dénombrés des bénéficiaires payés au titre du mois de décembre de chaque année, alors que ce sont des bénéficiaires (personnes ayant un droit ouvert à la prestation) au 31 décembre pour les autres aides.
2. Les dépenses d'ASH comptabilisées ici sont nettes des récupérations sur bénéficiaires, tiers payants et succession.
Note > D'autres dépenses d'APA non affectées à l'APA à domicile ou à l'APA en établissement sont comptabilisées dans « Autres aides » (35 millions d'euros en 2018).
Lecture > En 2018, la dépense brute totale est de 7,7 milliards d'euros.
Champ > France métropolitaine et DROM, hors Mayotte.
Source > DREES, enquête Aide sociale.

Personalised Autonomy Allowance (APA) - Some figures

- At home:
  - → There are four expenditure ceilings depending on the level of disability:
    - €672 for the least dependent (GIR 4) / €1,737 for the most dependent (GIR 1)
  - → Beneficiaries are required to contribute progressively to the care plan based on their income:
    - €0 with an income of less than €811 (median pension in 2024 = €1,626 gross per month)
    - 22% with an income of £1,500
    - 90% for income above £2,986
  - → The average care plan is €559 per month. This requirement is covered by 75% of the APA
  - → In addition, there is a tax credit equivalent to 6.5%.
  - → The average balance for a beneficiary is €72 (variable depending on the level of dependency and income)
- In institutions:
  - → the average cost of a stay was €2,382 per month in 2017:
  - → Elderly people then receive an average of €419 per month in assistance.
  - → The average out-of-pocket expense (before taking ASH into account) is therefore €1,965 per month.
    - 76% of residents are unable to finance their accommodation costs from their "current" resources alone
  - → The ASH intended for the poorest covers an average of €860 when paid
  - → Even after deducting ASH beneficiaries, 60% of residents remain unable to finance alone their accomodation

Autonomy policies now cover

- Social assistance under the authority of the « département »:
  - → CNSA (APA/PCH found) or other State transfer and departemental economic ressources
  - → Economic participation of beneficiary following income or asset
- Nursing care (at home or nursing home) under the authority of the ARS:
  - → Social security found (health national inssurance)
  - → Almost no participation
- General prevention under the authority of local authorities:
  - → State transfer and local taxes
  - → Economic participation depend of the municipality
- "Dependency prevention" under the authority of pension funds and other administrations
  - → Fund by national public pension fund in majority
  - → No participation

Organising an offer

Quick look at how the offer is structured

Home care 200,000 FTEs for APA

- Private non-profit
  - → All areas
  - → Often approved by the department
  - → Mandatory accreditation
  - → Low out-of-pocket expenses
  - → Significant cost to public finances
  - → Highly qualified
  - → Better working conditions
- Public
  - → All areas (tendency to remain in rural areas)
  - → Residual
  - → Approved, no out-of-pocket expenses
  - → Graduate
  - → Good working conditions
- Direct employment (25% of workers)
  - → All areas
  - → Moderately represented
  - → Free pricing but generally less expensive
  - → No intermediation (remnants of domestic service)
  - → Low level of qualifications
  - → Working conditions vary greatly
- Private for-profit
  - → Urban centre
  - → Often more expensive
  - → Mandatory accreditation
  - → Remaining costs to be paid by the beneficiary
  - → Strongly represented and growing

Institutional service provision

- Mostly public (44% of operators in decline, with 295,000 beds in 2023)
  - → Rural
  - → Social welfare approved
- Private non-profit (32% of operators and 177,000 beds, increasing)
  - → All areas
  - → Agreement with the department
  - → Low out-of-pocket expenses
- Private for-profit (24% of operators and 137,000 beds, growing)
  - → Urban centre
  - → More expensive
  - → Out-of-pocket expenses for the beneficiary
  - → Under-represented but growing

Challenges facing the French system, divisions and prospects

Persistence of the divide between disability and ageing

- Different economic investment (different instruments)
- Segmentation by age and distinct volumes
- Historical construction of categories
  - → Much more advanced exchange of practices and reflection on the disability side, which can feed into practices on the ageing side.
  - → Possible synergies in administration (ongoing) and services (forthcoming)
  - → Constraints linked to the scarcity of resources.

Health and social care coordination

- Coordination issues vs. autonomy of fields
- Different funding sources (individuals/organisations)
- Differences in resources
- Balance of power between sectors.

  →But a form of equilibrium compared to other systems studied