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Economic Evaluation

An Analysis of the Public Financial Support Eligibility Rule for French Dependent Elders with Alzheimer's Disease

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ABSTRACT

Background: It is crucial to define health policies that target patients with the highest needs. In France, public financial support is provided to dependent patients: it can be used to finance informal care time and nonmedical care use. Eligibility for public subsidies and reimbursement of costs is associated with a specific tool: the autonomie gérontologie groupes iso-ressources (AGGIR) scale score. **Objective:** Our objective was to explore whether patients with Alzheimer's disease who are eligible for public financial support have greater needs than do noneligible patients. **Methods:** Using data from the Dépendance des patients atteints de la maladie d'Alzheimer en France study, we calculated nonmedical care expenditures (in €) using microcosting methods and informal care time demand (hours/month) using the Resource Use in Dementia questionnaire. We measured the burden associated with informal care provision with Zarit Burden

Interview. We used a modified two-part model to explore the correlation between public financial support eligibility and these three variables. **Results:** We find evidence of higher informal care use, higher informal caregivers' burden, and higher care expenditures when patients have an AGGIR scale score corresponding to public financial support eligibility. **Conclusions:** The AGGIR scale is useful to target patients with the highest costs and needs. Given our results, public subsidies could be used to further sustain informal caregivers networks by financing programs dedicated to lowering informal caregivers' burden.

Key words: Alzheimer's disease, dependence, informal care.

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Introduction

The growing burden of dependence on others in the elderly population is a major problem in most industrialized countries. As per the 2012 Aging report, the elderly population will represent 20.3% of the total European population by 2020, raising large financial needs [1]. Specifically, proximity to death is associated with an inflation of care expenditures [2,3], which can represent up to one-third of health care costs over a lifetime for people surviving after 85 years [4]. This increase in care expenditures is particularly observed among dependent elders: several studies showed the existence of a strong correlation between dependence on others and needs. In the United States, there was evidence that dependence in the elderly population was associated with higher informal care demand and higher medical and nonmedical care expenditures [5,6]. In Germany, individual dependence-related expenditures were estimated to represent between €6100 and €9926 per year [7]. In Ireland, a recent study confirmed that correlation: a higher dependence level in the elderly was associated with a €796 increase in total care

expenditures [8]. In other words, elders with disabilities are high-needs high-costs people.

Despite these identified financial needs, the current economic crisis constrains most countries to public spending cuts. There are two direct consequences of this situation. First, recent research has warned against the growing inequalities in access to community care. For the poorest people, dependence care is becoming unaffordable, leading them to dramatically reduce their consumption. For instance, the analysis of a French survey of 3500 respondents provided evidence that almost 33% of elderly people with disabilities living at home receive no care, raising concerns that long-term care lacks among people with lower socioeconomic status [9]. Second, the demand for informal care is increasing, especially for patients with Alzheimer's disease (AD), who heavily rely on informal caregivers' assistance. In Europe, there are more than 6 million people with AD, requesting the assistance of 10 million informal caregivers [10]. In France, the per-person expenditures for community-dwelling patients with AD were estimated to represent €2918 per month, 80% of which were coming from

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informal care consumptions [11]. These two consequences underline the need to use reliable health policy tools to target high-costs and high-needs dependent elders.

This article focuses on the French public policy for elderly people facing autonomy losses. In France, disability benefits are provided to dependent patients to sponsor expenditures in dependence-related nonmedical services: the allocation personnalisée d'autonomie (APA). Specifically, APA can be used to remunerate informal care time when the caregiver is not the spouse and to pay for nonmedical expenditures necessary to maintain individuals' autonomy. Eligibility for APA depends on an evaluation of individuals' level of autonomy for social, mental, functional, and physical activities. That evaluation uses an original tool: the French autonomie gérontologie groupes iso-ressources (AGGIR) scale [12]. The AGGIR scale allows classifying elderly people into six so-called groupes iso-ressources (GIR) categories: GIR6, GIR5, GIR4, GIR3, GIR2, and GIR1. Elderly people rated GIR1 are the most dependent, whereas GIR5 and GIR6 people are considered as autonomous. Four GIR categories lead to APA eligibility: GIR1, GIR2, GIR3, and GIR4. Once eligibility has been stated, each person receives an individualized care plan defined by a team of clinicians.

The care plan is one of the main drivers of the APA generosity because it usually involves investment in specific equipment (alarm services etc.) and use of home help (maid, meals-on-wheels, etc.). The APA generosity is progressive, and it increases with the AGGIR scale score. Legal thresholds define the maximum public participation provided by APA: €1312.67/mo for GIR1 people, €1125.14/mo for GIR2 people, €843.86/mo for GIR3 people, and €562.57/mo for GIR4 people. It has been estimated that APA covers 80% of individuals' care plan expenditures, representing on average of €489/mo [13]. In 26% of the cases (44% for GIR1 and 36% for GIR2), the care plan expenditures reach the legal threshold, showing that APA does not cover all financial needs [14].

In a context of important budgetary constraints, financing APA is becoming a major concern for public finances. In particular, APA eligibility rules are debated because with more people eligible, expenditures are expected to grow. From a macroeconomic perspective, dependence-related expenditures represent up to €20 billion, 17.7% of this amount being used to finance APA provision to 170 per 1000 individuals older than 75 years [13]. The proportion of people receiving APA should increase in the future. In 2010, 1.2 million people were dependent in France and public spending for GIR1 to GIR4 people represented €6.8 billion. With the aging of the French population, there will be 1.5 million dependent people in 2025 [14]. In this context, introducing specific rules for patients with AD is of concern [14].

In this article, we explore whether patients with AD who are eligible for APA have greater needs than do noneligible patients. Specifically, we compare eligible patients with noneligible patients according to three main dimensions of help: informal care providers' well-being losses, patients' use of informal care, and patients' nonmedical care expenditures. Our objective was to shed light on a central question: is it relevant to use the GIR4 level as a dependency cutoff for APA eligibility; in other words, are individuals' needs and costs significantly increasing under GIR5?

Methods

Data

We used data collected from the Dépendance des patients atteints de la maladie d'Alzheimer en France (DEP-FR) study, which was specifically designed to explore the association between dependence and three economic variables: care expenditures (medical and nonmedical), informal care time production (from both primary and secondary caregivers), and the burden associated with the informal care production. This cross-sectional observational study was conducted between 2010 and 2012. The recruitment was performed in the university hospitals of Toulouse and Bordeaux, which are two French academic centers with a strong specialization in dementia care and an extensive expertise in the design of observational studies in dementia.

Patients were recruited in both the community and from institutions when visiting the hospital. Our sample consisted of 196 elderly (70+ years) people with a diagnosis of probable AD, according to the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association criteria [15]. These patients were recruited with the help of their primary informal caregivers, who were asked to fill the Resource Use in Dementia LITE 2.4© questionnaire. This questionnaire was specifically designed to estimate the utilization of informal and formal resources for dementia-related activities and is widely used in the literature [16–18]. Caregivers self-reported how much caring time was typically allocated among three main assistance components: activities of daily living, instrumental activities of daily living, and supervision. Activities of daily living involved basic activities (dressing etc.). Instrumental activities of daily living involved more sophisticated activities (shopping etc.). Supervision was defined as an activity dedicated to the prevention of the risk of dangerous behavior and events (accidents with fire etc.). These activities are relevant for the care of patients having dementia [16,17]. In consequence, there was no need to separate dementia-specific caregiving activities from other activities.

Dependent Variables

Our analyses focus on three dependent variables. First, the primary informal caregivers' burden was measured using the Zarit Burden Interview (ZBI) assessment [19]. The ZBI score ranges from 0 (lowest burden) to 88. Second, we summed the time demands (hours/month) for both primary and secondary informal caregivers. Third, we calculated patients' total nonmedical care expenditures for a 6-month period including home help, mobility help (taxi services), meals-on-wheels, stays in dementia and nondementia-specific accommodations, and nursing homes nights. Costs were calculated from a societal perspective. We assumed that two meals were delivered per day and that 4 hours of adult day care was received for each occurrence. Costs involving patients' transportations were assumed for a complete round trip. Table 1 describes unit costs actualized in euro for the year 2012. For consistency with

Table 1 – Unit costs calculated from the societal perspective.

Item	Unit	Value in 2012€	Source
Maid	Hour	9.40	Authors' calculations based on online tariffs
Nondementia-specific accommodation	Night	20.73	Authors' calculations based on online tariffs
Dementia-specific accommodation	Night	60.27	Authors' calculations based on online tariffs
Nursing home	Night	71.58	Authors' calculations based on online tariffs
Meals-on-wheels	Meal	8.85	Authors' calculations based on online tariffs
Transportation	Ride	56.95	French Ministry of Health

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