Health Policy 119 (2015) 1338–1348

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

The non-take up of long-term care benefit in France: A pecuniary motive?

Yves Arrighi[a,d], Bérengère Davin[b,c], Alain Trannoy[a], Bruno Ventelou[a,c,*]

[a] Aix-Marseille Université (Aix-Marseille School of Economics, GREQAM EHESS), Vieille Charité, 2 rue de la Charité, 13002, Marseille, France
[b] Aix Marseille Université, (Aix-Marseille School of Economics, SESSTIM UMR 912, Inserm IRD), 23 rue Stanislas Torrents, 13006, Marseille, France
[c] ORS PACA, Observatoire Régional de la Santé Provence-Alpes-Côte d'Azur, 23 rue Stanislas Torrents, 13006, Marseille, France
[d] LIRAES (EA 4470)—Université Paris-Descartes, Sorbonne Paris Cité, 45 rue des Saints Pères, 75006, Paris, France

ARTICLE INFO

Article history:
Received 21 July 2014
Received in revised form 23 June 2015
Accepted 11 July 2015

Keywords:
Long-term care
Social benefit
Non-take-up
Multilevel model

ABSTRACT

With aging populations, European countries face difficult challenges. In 2002, France implemented a public allowance program (APA) offering financial support to the disabled elderly for their long-term care (LTC) needs. Although currently granted to 1.2 million people, it is suspected that some of those eligible do not claim it—presenting a non-take-up behavior. The granting of APA is a decentralized process, with 94 County Councils (CC) managing it, with wide room for local interpretation. This spatial heterogeneity in the implementation of the program creates the conditions for a "quasi-natural experiment", and provides the opportunity to study the demand for APA in relation to variations in CCs' "generosity" in terms of both eligibility and subsidy rate for LTC. We use a national health survey and administrative data in a multilevel model controlling for geographical, cultural and political differences between counties. The results show that claiming for APA is associated with the "generosity" of CCs: the population tends to apply less for the allowance if the subsidy rate is in average lower. This pecuniary trade-off, revealed by our study, can have strong implications for the well-being of the elderly and their relatives.

1. Introduction

Most developed countries have to cope with population aging [1] and face difficult challenges particularly with regard to healthcare, retirement systems and labour market supply [2]. The structure of long-term care (LTC) insurance systems differs between countries, depending on the national structure, history and culture, as well as on economic performance [3,4]. Treating and caring for the elderly entails both public and private costs that amount to billions of Euros per year. In France, the economic burden of LTC is particularly high, with an estimated public cost of about 21.6 billion Euros in 2009 (around 1% of the GDP) [5] and an equivalent amount for the indirect costs generated by informal care [6].

1.1. Public LTC policy in France

The LTC policy has been a long process since the 1980s in France, leading to a rather complex system [5]. The healthcare system covers medical and health costs but does not account for a large part of LTC expenditures, particularly

* Correspondence to: 23 rue Stanislas Torrents, 13006 Marseille, France. Tel.: +33 0 4 91 89 59 16.
E-mail addresses: yves.arrighi@gmail.com (Y. Arrighi), berengere.davin@inserm.fr (B. Davin), alain.trannoy@univ-amu.fr (A. Trannoy), bruno.ventelou@inserm.fr (B. Ventelou).

http://dx.doi.org/10.1016/j.healthpol.2015.07.003
0168-8510/

non-medical home care which have to be paid out of pocket if the patient does not have a private insurance contract. Over the last decade, France has implemented various governmental policies to deal with this issue [5,7], since the demand for private LTC insurance is relatively small compared to the magnitude of the disability risk (only 3 million of French people hold a LTC insurance in 2008 for an adult population of 40 million [8,9]). The main public benefit is a cash-for-care allowance implemented in 2002 which currently covers 1.2 million beneficiaries, called 'Allocation Personnalisée d'Autonomie' or APA (Personalized Autonomy Allowance) [5,10]. This scheme is a national program but is implemented at the local level by public County Councils ('Conseils Généraux': political authorities managing the French territories called "départements", hereafter CC) [11]. The program is based on the principle of universality and is granted to people aged 60 and over living either at home or in institutions and needing help with daily activities. Disability is assessed using a scale distinguishing six disability classes (AGGIR grid). Only the first fours entitle individuals to receive the benefit, in the form of a subsidy for home care services [12]. The care package is determined by a team of professionals according to the needs of the recipients. The paid carers can either be professional workers or relatives (except spouses) [5].

In order to guarantee access to the same services across the country, each level of disability entitles recipients up to a maximum preordained allowance, which in 2014 was determined as follows: 1304.84 euro per month for the first disability class, 1118.43 euro for the second class, 838.82 euro for the third class and 559.22 euro for the fourth class [5]. Below a fixed income threshold (nationally set at 734.66 euro per month in January 2014), the recipient does not have to contribute to the care package (according to the principle of social solidarity); above this threshold, he/she pays part of the care-package according to his/her household income (the wealthiest families may have to copay up to 90%). Thus, every eligible person can receive the allowance, but their co-payment varies in line with their means.

1.2. Studies of non-take-up

It is suspected that part of the population eligible for the APA does not apply for it. The non-take-up behavior is observed for many social benefits and in many countries. It can be seen as a failure of the welfare state to provide those in need with the minimum necessary resources. The literature on the determinants of non-take-up of social benefits is usually consistent with standard economic theory of rational utility-maximizing individuals (e.g., [13,14]). Some studies stress the direct and indirect costs of applying for benefits, including both objective barriers and subjective motives [15]. Stigma and disutility associated with claiming a social benefit are suggested as possible explanations. Additionally, non-take-up may simply reflect a lack of awareness about the availability of the particular scheme, which has recently been observed for the APA [16], or an expectation that the cost of applying for the social program would exceed the amount of the benefit [17].

In France, non-take-up is a topical issue, especially in the social sector [18]. For example, in the healthcare field, a recent paper analysed the low take-up rate of a complementary health insurance program for the poorest populations [19]. In 2005, a monitoring agency analysing non-take-up of rights and services ('Observatoire des non-recours aux droits et services'—ODENORE) studied the APA from a qualitative point of view. The results highlighted that 9% of eligible elderly people did not claim it [20]. Many factors may explain this situation. First, the elderly may not be aware of the benefit or believe that the claiming procedure is too complex. Second, they may feel that taking up a social benefit is proof of disability (stigma). Third, they may have enough money to independently manage their home care. Fourth, they may refuse any intrusion into their administrative files or into their private life. Besides these factors, the non-take-up of the APA could be impacted by the level of the allowance itself (e.g. the subsidizing rate of the care package), as a result of a trade-off between the costs (queuing, stigma, etc.) and benefits.

1.3. Aim

This study aims at examining the factors associated with the propensity to apply for the APA. More precisely, it studies whether the take-up behavior could be influenced by the level of subsidy the individuals expect to obtain. Indeed, the local CCs who manage the APA may be more or less "generous" in its implementation: some spatial heterogeneity can be observed in terms of eligibility conditions and subsidized amounts. Part of these differences may be explained by disparities in the socio-demographic structure of the CCs (proportions of rural population, of poor elderly people, etc.). However, a study found that even after controlling for disability levels in the elderly population, the average subsidizing rate for the care package still varied from 70% to 90% across CCs [21]. This 20 points gap could be seen as "discretionary", probably reflecting factors such as political tendencies (left or right) and/or whether the median-voter is old or young. This heterogeneity will be therefore considered as a "quasi-natural experiment", which enables to examine APA take-up with respect to variations in the benefits provided.

2. Material and methods

To test whether CC generosity is correlated with individual take-up behavior, we matched survey micro-data with two types of data collected at the CC-level. The first-one contains information on the APA program itself, the second-one records variables that might impact APA demand and/or APA generosity—and will be used as controls.

2.1. Data and variables

2.1.1. Micro-data

In 2008, the French National Institute of Statistics (INSEE) and the Ministry of Health (Direction de la Recherche, de l'Evaluation, des Etudes et des Statistiques—DREES) performed a national representative survey on