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Financing long-term care for frail elderly in France: The ghost reform☆☆

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ABSTRACT

Like many welfare states, France is faced with increasing demand for long term care (LTC) services. Public LTC coverage has evolved over the past 15 years, reaching a coverage depth of 70%. Nonetheless, it does not provide adequate and equitable financial protection for the growing number of frail elderly individuals, who are expected to constitute 3% of the population by the year 2060. Since 2005, various financing reform proposals have been debated, ranging from a newly covered risk under the social security system to targeted subsidies for private LTC insurance. However, to date no reform measure has been enacted. This article provides a brief history of publicly financed LTC in France in order to provide a context for the ongoing debate, including the positions and relative political power of the various stakeholders and the doubtful short-term prospect for reform.

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1. Introduction

Many countries face the pressure of a rapidly growing aging population. In France, this is due to increased life expectancy but not to declining fertility rates, as, for instance, in Germany and Japan. The post-World War II baby boom effect will exacerbate this trend in the medium term, and the population aged over 75 years is expected to nearly double by 2050, representing 15.6% of the population compared to 8% today [1]. Because the probability of becoming dependent greatly increases with age, the number of frail elderly persons is expected to grow 40% by 2030 and 60% by 2060, rising from 1.15 million in 2010 to 1.55 million in 2030 and 2.3 million by 2060, corresponding to an estimated 3% of the population. As a result, there is an increasing need for long term care (LTC) to provide personal assistance to frail elderly persons at home or in nursing facilities or other residential care settings. In 2010, French LTC spending was estimated at €34 billion, or 1.73% of GDP, of which 70% was publicly funded [2,3].

Because of its expense, the increasing demand for LTC services has driven welfare state governments to search for solutions to ensure equity of access through public financial protection. These policies have taken various forms in the past three decades [4]. In 1995, Germany established a universal LTC social insurance system financed largely through payroll taxes with benefits in the form of cash or in-kind services. In 2000, Japan created a public insurance system funded by a combination of premiums and taxes that finances approved in-kind services.

In France, public coverage of LTC has evolved over time, particularly the last 15 years [5]. Today, however, coverage

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is inadequate, and financing reform has been called for since 2005 [6]. Various initiatives have been announced, but none has been enacted. This paper describes the development of the financial protection system through 2004. It explores the different reform options that have been proposed as well as possible explanations for the government's inaction to date.

2. Addressing the need for financial protection for LTC: a history

Shortly after the establishment in 1945 of the social security system (SSS), which offered benefits including social health insurance (SHI) and social retirement insurance (SRI), the question of addressing the need for publicly financed LTC was raised. Designated hospitals for poor and isolated frail elderly persons existed as early as the 18th century [7] and have been covered by SHI since its creation. The Laroque[1] report in the early 1960s [8] introduced the "maintenance at home" policies, including the creation of at-home services along with adequate public coverage to ensure access, thus constituting a genuine public policy. SSS participated by offering coverage for at-home services such as catering, shopping and housekeeping under SRI and personal care for hygiene or community nursing services under SHI. Fiscal rebates were also introduced.

The SHI funding shortage associated with the 1970s financial crisis and the increasing demand for hospital facilities led to the creation of "long term care sections" in retirement homes in lieu of expanded hospital capacity. Limited to 25% of a home's capacity, this section provided LTC financed by SHI to elderly individuals needing care, who paid the same lodging and catering fees as other retirement home residents. In addition to providing additional capacity, this option decreased SSS expenditure and shifted a share of the cost to users, who previously paid almost nothing for catering fees in hospitals.[2]

Local authorities (called *départements*) have always been involved in policies for the elderly. However, prior to decentralization in 1980 their participation in LTC was marginal, consisting mainly of social aid for lodging in retirement homes, a responsibility they maintain today. Thereafter, local authorities were charged with disability policies, including financial responsibility for an allowance established in 1975 to pay for LTC services for handicapped people (*ACTP; allocation compensatrice tierce personne*). However, because of unclear wording in the legislative texts, by 1993 over 70% of beneficiaries were frail disabled elderly individuals at home or in nursing homes. This resulted in financial difficulties for local authorities due to annual cost increases of nearly 10% [9]. In 1996, the annual cost for frail elderly was equivalent to €960 million.

[1] Pierre Laroque was the author of the laws establishing the French Social Security system.

[2] The hospital catering fee is approximately one-quarter of the fee charged in nursing homes, and often that fee is not applicable if the patient has 100% SHI coverage due to a qualifying long-term illness.

As a result, the first specific LTC financing reform was enacted in 1997. It established a means-tested allowance for elderly individuals with resources under approximately €1000 per month called the PSD (*prestation spécifique dépendence*) and administered by local authorities. An official 6-level grid (AGGIR) [10] was used to define a person's level of dependency/disability, which determined the amount covered in a nursing home and the maximum amount for covered services at home, where an assessment of individual need was made resulting in a "care plan". The allowance successfully reduced local authorities' expenditure to €760 million in 1999 because of its lower income ceiling and because it provided for recovery of expenses from elderly persons' estates after death, which was a deterrent to participation. While the number of frail elderly in need of care was estimated at around 800,000, in 2001 only 175,000 benefited from financial protection (measures are summarized in Table 1).

In order to improve access, PSD was transformed into APA (*Allocation personnalisée d'autonomie*). Unlike PSD, it provides universal coverage and abolishes recovery of expenses from estates. As under PSD, benefits are need-based, but the level of coverage is means-tested, with an income-related user co-payment. APA enlarges access to an additional level of dependency, covering the four highest AGGIR levels as opposed to three previously. To fund the expected additional expenditure, a mixed system of funding was organized. In addition to local authorities' contributions, a national funding source was established to generate additional revenue and reduce disparities in local authorities' funding capacities. It was initially financed by a 0.1% contribution to the general social contribution rate,[3] the revenue-based tax that finances SSS and is higher for wage-based revenue than pensions.

APA was far more successful than expected, and by 2003 the number of beneficiaries approached 800,000, increasing to 1 million in 2006 and 1.2 million in 2012. Following the 2003 summer heat wave during which 15,000 frail elderly died, a 2004 reform was enacted to improve the quality and capacity of LTC. It was financed by a "solidarity and autonomy contribution" (CSA), a 0.3% tax on wage-earner income equivalent to an unpaid working day.

[3] Since 1998, as a result of attempts to broaden the social security system's financial base, employees' payroll contributions have fallen from 6.8% to currently 0.85% of gross earnings. They were mainly replaced by an earmarked tax introduced in 1991 called the 'general social contribution' (CSG) based on total income. The CSG rate varies depending on the source of income. It initially had a two-level rate but slowly evolved to a range with a higher rate for revenue from capital or from gaming (for example, lotteries and casinos) and a lower rate applicable to revenues of those with low incomes. It is 7.5% on earned income (of which 5.1% goes to SHI), 8.2% on capital (5.95% for SHI), 9.5% on winnings from gambling, 6.6% on pensions and 6.2% on benefits (for example, allowances for sick leave and maternity leave). This rate is decreased to 3.8% of earned income for those with low incomes who are exempted from income taxation, which represents almost half of all French households. As such, CSG can be considered a progressive tax. A share of CSG contributions is generally tax deductible from income: 5.1% on earned income, 4.2% on benefits and 3.8% on other sources of revenue. In 2007, 70% of the money raised via the CSG was directed to SHI.

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