



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 Laroque¹ 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.

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 dépendance*) 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.

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.

Table 1

Summary of LTC measures implemented and their main characteristics.

Name of Policy	Year/law	Circumstances/objectives	Description	Additional source of funding	Options considered and rejected	Implications for equity	Results	Political wing	Financial situation	Political power
PSD	1997 Law of 24 January 1997	– Use of the allowance for handicapped persons by elderly cost: €0.96 billion in 1996 – Contain cost for local authorities	– Allowance means-tested – Variable access based on level of dependency – Covers 3 highest of 6 levels of dependency	None	Raising additional revenue	Decreases equity of access by decreasing coverage	Decrease in expenditure by local authorities to €0.76 billion in 1999	Right	Bad	Weak
APA	2001 Law of 21 July 2001	– Under-development of PSD: only 145,000 persons covered while frail elderly are estimated at 800,000 – Increase coverage up to 800,000 in 4 years	– Universal coverage – Income-related benefit: level of co-insurance depends on income – Covers 4 highest levels of dependency	– Local tax – Transfer of 0.1% of national SSS tax on revenue (CSG)	– Social insurance system as part of the SSS – Additional increase of CSG by 0.1% to secure funding	– Local taxes: Increases geographic inequity – Some are not proportional to income and thus more regressive	– Very successful beyond expectations – Number of persons covered increased up to 1.2 million in 2011	Left	Good	Neutral
Law modifying the APA	2003 Law of 31 March 2003	– €1.2 billion annual shortfall in fund for financing APA – Expected number of beneficiaries increased to 700,000 while 500,000 expected in 2003	– Shift €400 million to local authorities – Shift €400 million to users – Government borrowing of €400 million for 3 years	None	Additional increase of CSG by 0.1%	– Decreases fair financing – Increases geographical inequity		Right	Good	Good
CSA	2004 Law of 30 June 2004	Increase national funding of APA	Workers give up one day of wages to increase funding for APA	– 0.3% on income of wage earners only, excluding retirees and self-employed – 0.3% on estate revenues and investment products	– Increasing CSG by 0.1% – 0.3% on all income	Decreases equity in financing	– APA cost for local authorities increased from €1.8 billion in 2003 to €2.8 billion in 2006 and €3.8 in 2012 (8.8% of annual increase), while state expenditure increased by less than €0.3 billion (0.9% of annual increase) – the local authorities share increased from 57% to 69%	Right	Good	Good

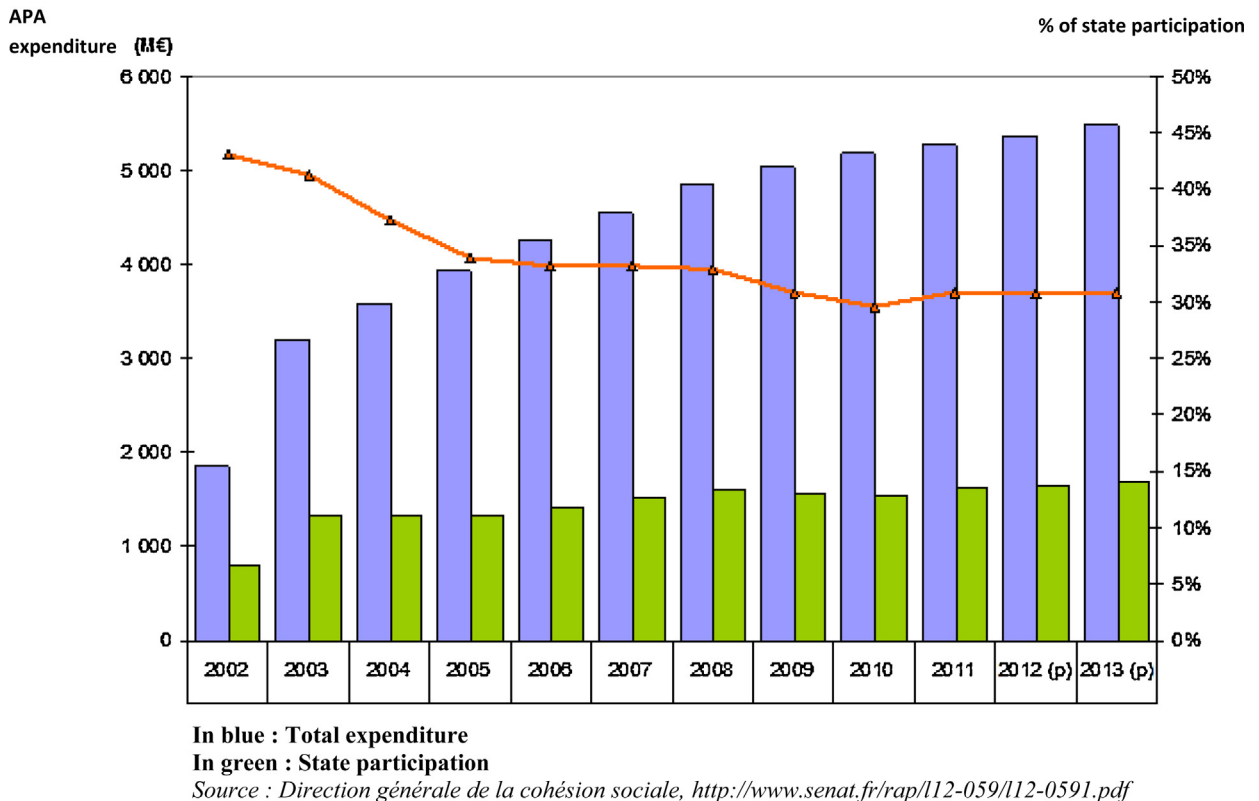


Fig. 1. Trends in the APA and central government's share since 2002. In blue (left bar for each year): total expenditure. In green (right bar for each year): state participation.
Direction générale de la cohésion sociale, <http://www.senat.fr/rap/l12-059/l12-0591.pdf>.

3. Proposed reform options for funding LTC

By 2006 two major questions were raised: how to ensure the sustainability of APA funding given the rapidly increasing financial burden on local authorities (2.8 times higher in 2006 than 2002; Fig. 1) and how to decrease the burden of user charges that exceed the average revenue of elderly persons due to the cost of lodging and catering fees in nursing homes (€1800 on average in 2009 [1,11]). An estimated additional €400 million will be required annually for the next 20 years to finance the anticipated care needs of the elderly and dependent population [12].

By the end of 2007, the newly elected right-wing government planned to establish an insurance scheme covering LTC as part of SSS. However, the reform was postponed many times to 2008, 2009, then 2011 and ultimately was not enacted. Moreover, in the debate, there was a shift from a SSS-type system to a financial protection system encompassing a range of options [13,14]: (1) raising additional funds to strengthen the current system; (2) increasing elderly individuals' ability to fund user charges; (3) switching to a new system of financial protection (see Table 2).

Raising additional revenue implies an increase in public levies, which the right-wing government had promised not to do and which had been avoided in creating PSD in

1997 and modifying APA in 2003. An equalization of social tax rates (CSG and CSA) for certain populations, mainly elderly and self-employed persons, to the levels applicable to the rest of the population was proposed by most experts and in most parliamentary reports [1,12,15]. However, these favored populations are classically part of the right-wing electorate. Similarly, recovery of charges from elderly beneficiaries' estates was unthinkable because of its intense unpopularity as illustrated by the deterrent effect it had under the PSD in 1997.

The ability of an individual to pay user charges increases if he buys complementary private insurance or has recourse to his estate or life insurance savings while alive. This proposal is as unpopular with the elderly population as recovery of charges from estates. Of all options, private LTC insurance was the government's favorite because it does not require increased taxes and financial incentives could be developed to assist the poorest individuals in purchasing contracts. It had the advantage of being politically viable because it was not seen by the general public as creating inequity and the proposed financial incentives were popular. While France is the second largest world market after the US for LTC insurance [16], a model contract is necessary in order to implement government subsidies. However, negotiations with insurance firms reached an impasse as insurers insisted on using their own risk assessment tools rather than the public 6-level grid and also wanted to

Table 2

Summary of LTC policy options after 2006 and their main characteristics.

Policy option	Description	Additional source of funding	Implications for equity	Stakeholders' positions	Government's political will	Remarks
2007–2011: Right-wing Sarkozy presidency						
Strengthen the current system: raise additional revenues						
Increase SSS tax on retirees	Increase the SSS tax (CSG) on retirees' revenues from 6.6% to wage earner level (7.5%)	Raises €1.2 billion	Increases equity	Opposition from retirees expected	Weak	Government strongly opposed to increasing taxes
Double CSA		Raises an additional €2.3 billion	Neutral	Strong opposition from wage earners' unions	Weak	Government strongly opposed to increasing taxes
Broaden CSA base	Broaden CSA base to include self-employed and retirees	– 0.3% on all kinds of income – Raises an additional €0.95 billion	Increases equity in financing	Strong opposition by self-employed unions and retirees	Weak	Government is strongly opposed to increasing taxes Self-employed and retirees are classically part of the right-wing electorate
Eliminate tax advantages of retirees		Raises approx. €2.8 billion	Increases equity in financing	Opposition from retirees	Weak	Retirees are classically part of the right wing electorate
Recovery of charges from elderly beneficiaries' estates	Part of the benefits paid by local health authorities to beneficiaries are recovered from their estates after death	Unknown	Increases equity in financing	Strong opposition from retirees	Weak	Retirees are classically part of the right-wing electorate
Increase individual ability to fund user charges						
Voluntary complementary private insurance incentive	– Tax incentives for purchasing a contract – Offers cash benefits	Does not raise additional funds for public financial protection	Decreases equity in financing	Unknown	Strong	Solution preferred by the government. However, negotiations with insurance firms failed. Insurance companies wanted to use their own assessment tools to estimate risk and adjust premiums rather than the national dependency grid.
Recourse to elderly beneficiary's estate and use of life insurance savings while they are alive	Setting up of new rules for life tenancy and use of use of life insurance savings to pay for lodging and catering fees in nursing homes	Unknown	Decreases equity	Opposition from retirees expected	None	Retirees are classically part of the right-wing electorate
Switch to another system SSS system	No longer under local authorities' responsibility	CSG increase from 0.1% raises €1.1 billion	Increases equity	Strong opposition by local authorities	Very weak	Proposed several times including in 2001 when APA was enacted, in 2004 when CSA was enacted, and in 2007 during the election campaign. Easily understandable by people. However, this option implies increased public levies, while public spending is 0.55% of GDP and the right-wing government opposed an increase in spending and promised not to rise taxes.

Table 2 (Continued)

Policy option	Description	Additional source of funding	Implications for equity	Stakeholders' positions	Government's political will	Remarks
Universal compulsory private insurance system	<ul style="list-style-type: none"> – Everyone required to purchase LTC contract starting at 40– 50 years old – Premiums depend on age on entering the system – Voucher for those with lower incomes 	A €33 monthly premium should result in €300–700 cash benefit	Increases inequity	<ul style="list-style-type: none"> – Unknown – Did not enter the public debate – But strong opposition by local authorities and a good share of the public would be expected 	Weak	<ul style="list-style-type: none"> – Adapted from the “ElderShield” system in Singapore – Contrasting opinions in the majority – 2 parliamentary reports in opposition [12,15]
2012: Left-wing Hollande presidency						
Strengthen the current system: raise additional revenues CASA, Additional CSA	<ul style="list-style-type: none"> – Broaden CSA base to include retirees and disability pensions but not self-employed income – Individuals with lower incomes exempted – 95% of revenue will be used to finance APA 	0.3% on pensions raises an additional annual €0.6 billion			Strong	<p>Measures included in the 2013 Social Security Finance law [18,19] by the newly elected left-wing government, which wants to support the role of local authorities (all are left wing) and has announced a reform for 2014 mainly focusing on improving prevention of dependency. Support for this policy option clearly expresses opposition to the development of private insurance. First message to retirees that they will participate in the financing of their future dependence.</p> <p>Law not offered by the government but proposed and accepted by the Senate (Senate majority is left wing) in October 2012 in order to alert the government that the enlargement of the CSA base should be broadened to include the self-employed [20]</p>
Broaden CSA base	Broaden CSA base to include self-employed and retirees	– 0.3% on all kinds of income raises an additional €0.95 billion	Increases equity in financing	Strong opposition by self-employed unions and retirees “who are mainly right wing”	Unknown	

adapt premiums over time, which would have exacerbated inequity of access to private insurance.

This effect on equity explains why a dramatic change from the APA to the fully private compulsory insurance system proposed in 2010 [15] was not examined further. Interestingly, a switch to a social insurance system under SSS, first evoked in the 1990s, was explored both in 2001 when the APA was developed and in 2004 when the CSA was created and has been invoked several times since 2006. However, it has never been the preferred option regardless of which political wing controlled the government or its political power at the time. There are several reasons for this, notably two. There is no agreement on who would manage this new risk (SHI, SRI. . .), but in any case it would not be at the local level. Local authorities are strongly opposed to giving up responsibility for LTC because of the visibility and political power it has provided them since decentralization in 1982 [14]. Moreover, while the French population generally favors public intervention for LTC (68% in 2009), only 50% would agree to pay a new social tax which, on top of the risk of further impairing the fiscal balance, made the decision of raising a new tax politically risky [13,16].

4. Discussion

France has a long history of public coverage of LTC and has achieved a 70% coverage depth that is relatively good. However, coverage varies widely among elderly people depending on their needs. The growing need for public funding in the coming decades is estimated to be three times higher than the expected growth of the population, which further threatens equity in financing.

While the SSS system was the main funding source for LTC after its creation, in the last four decades local authorities' responsibility for funding LTC has grown following the creation of a universal allowance with a means-tested co-insurance. Overall, this can be regarded as a shift from national solidarity-based financial protection to local tax-based financial protection. Despite the attempt to compensate for disparities among local authorities through a national funding source allocated based on needs and wealth criteria, this shift has increased geographical inequity. Moreover, it is more regressive, particularly because a share of local taxes is not income-based. This situation will worsen if no action is taken to reinforce national solidarity.

Increasing equity in financing by equalizing the LTC tax treatment of the entire population would be a logical first step. The previous right-wing government did not do so in order to cater to its electorate. The left-wing government elected in May 2012 appears willing to address this issue. However, increasing self-employed and retiree taxes up to the general population level will not be sufficient to finance the anticipated demand in the medium to long run.

A genuine political and societal choice is needed in order to strike the right balance between increasing the ability of elderly persons to use their own assets to pay for care and increasing solidarity. The new government has announced an LTC reform for 2014 to be phased in over the course of the presidency that is designed to improve

dependency prevention and quality of care but that does not specifically mention financing. As further evidence of this reticence, none of the three working groups set up by the government to address aging issues addressed this question in the reports they released in March 2013 [17]. Unlike the 2007–2011 period when LTC financing reform was announced by the President and entrusted to powerful ministers, this reform was announced by the newly appointed delegate minister, who has little power in the government and is unknown by the general population. Given the significant level of political support necessary to achieve financing reform, these developments do not offer much reason for optimism in the short term.

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