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► **To cite this version:**

| Blanche Le Bihan, Claude Martin. French social and long term care system. 2019. halshs-02058183

**HAL Id: halshs-02058183**

**<https://shs.hal.science/halshs-02058183>**

Preprint submitted on 5 Mar 2019

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# French social and long term care system

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Reference: B. Le Bihan, C. Martin, “French social and long-term care system”, *Global Social Security Review*, Korean Institute for health and social affairs KIHASA, vol. 7, Winter 2018, p. 5-15.

*Abstract: As “community care” has no exact equivalent in the French context, the authors focus on one of the major sector of social and community care which concerns elderly people confronted to a reduction of their autonomy, which correspond to the international denomination: long-term care (LTC). It presents the emergence, the current organization and main challenges of this policy in France.*

In France, the notion of “community care” (*soin communautaire*) never developed as such, probably because of the Republican model which insists, since the Revolution of 1789, on the direct link between the State and citizens. Since then, the intermediary bodies were never as recognized as they are in many other nations, in particular anglo-american ones. Even the French expression: “soin à domicile”, sounds very different compared to “home-care”, as domiciliation refers to an administrative localisation of the caring work, nothing similar to the notion of “home” (Lesemann & Martin, 1993). In the following article, we propose to focus on one of the major sector of social and community care which concerns elderly people confronted to a reduction of their autonomy, which correspond to the international denomination: long-term care (LTC)<sup>2</sup>.

## The French LTC policy: a layering process

Contrarily to the main sectors of the French social security system, LTC appeared recently as a public problem and a collective risk, which means only at the end of the 1980s. Since the mid-1970s and early 1980s, nevertheless, an important social and political debate emerged concerning the aging of the French population and the challenge to face it (see Box 1), underlying the absence of a specific policy and many overlaps between measures addressed to the handicapped and older old people (Martin, 2003).

Box 1: The demographic argument still represents a main issue until now. According to the current trends, by 2060 one third of French citizens will be over 60, including almost five million people over 85, compared to 1.4 million in 2015 (Blanpain N. et al., 2016). This

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<sup>2</sup> . This article is based on a report (Le Bihan, 2018) delivered to the [European social policy network](#) (ESPN) funded by the European Commission. We use different sections of the report to produce this paper. See the site <https://ec.europa.eu/social/main.jsp?catId=1135&intPagelId=3589>

demographic evolution is due to increased life expectancy combined with the baby-boomers' arrival at old age (Lecroart et al. 2013). Because the probability of becoming dependent increases with age, the number of elderly people is expected to rise 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.

But this debate, fed by a great number of official reports, never reached a decision to build up a policy until the early 1990s. Then the policy emerged and developed incrementally. We could even consider it as a layering process. This process led to a fragmented system centred on a specific allowance: l'*Allocation personnalisée à l'autonomie* (APA) (personal allowance for autonomy).

### A specific policy measure: The APA

Long-term care policy in France is based on a cash-for-care scheme, introduced in the late 1990s as the Specific Allowance for Dependency (1997). Focusing on situations of "dependency" – an expression abandoned afterwards, according to its stigmatizing image- , the benefit aimed at meeting the needs of elderly people who were not covered by health insurance (care opposed to cure), by helping them identify their needs and pay for care services. It was reformed in 2002 and became the personal autonomy allowance (*Allocation personnalisée d'autonomie* - APA). Managed by the *départements*<sup>3</sup>, the APA is paid to any person aged 60 or over who needs assistance to accomplish everyday activities or needs to be continuously watched over. Each of the four levels of dependency gives access to a maximum amount (table 1), which is then adjusted according to the recipient's needs and level of income. At home, the allowance is paid either to finance a specific "care plan" elaborated by a multidisciplinary team (health and social professionals), after an assessment of the needs, or in a residential home. The use of the benefit is controlled and the multidisciplinary teams in the *départements* are in charge of following up the situation.

The APA represents over €5 billion, of which 70% comes from the *département* and 30% from the National Solidarity Fund for Autonomy (CNSA), a specific fund created in 2004 to cover partly the needs of both handicapped and dependent elderly people.

**Table 1: Characteristics of the APA (Personal Autonomy Allowance)**

Eligibility criteria	<p>At least 60 years old</p> <p>Mid to high level of dependency (Gir 4 to Gir 1) according to national assessment grid: AGGIR grid which distinguishes 6 levels of dependency.</p> <p>Proportional to the level of income: below a monthly income of €800 recipients do not contribute to the funding of the care plan; above €2945 of monthly income recipients contribute 90% of the funding.</p>
Amount of the allowance (per month)	<p>Gir 1 (highest level of dependency): € 1713 max</p> <p>Gir 2: €1375 max</p> <p>Gir 3: €931 max</p> <p>Gir 4: €662 max</p>

<sup>3</sup>. A specific local authority which is intermediary between municipalities and regions and in charge of social policies.

Beneficiaries	1.25 million beneficiaries in 2015 (8% of people aged over 60)  60% of APA recipients live at home and 40% in residential homes. 45% have been assessed at Gir 4 (mid-level) dependency. 50% are more than 85 years old and 3/4 are women
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Source: Ministry of health and social affairs

APA concerns mainly home-care, as 750,000 recipients are cared for in their own households, first by informal carer, frequently supported by professional carers and services. The number of beneficiaries has stabilized since 2012, but statistics anticipate a significant increase around 2030-2040 as the baby-boom generation reaches old age. Estimates consider that the number of recipients could reach 2 million in 2040.

### A fragmented system

LTC policy in France cuts across different policy sectors – health, social and medico-social<sup>4</sup> – and involves several levels of governance: the state, regions, *départements* and municipalities. In France, the government defines national health and social policies through legislation, and different territorial levels are involved in managing and funding the two sectors. Regional and local administrations execute national health policies under close supervision from the government through the Social security system, whereas the decentralized French local authorities – *départements* – are responsible for social policies. In the elderly care sector, the *départements* have the obligation to define their local policy orientations, finance and implement the national personal autonomy allowance (APA), and regulate care services within their territory. In addition, municipalities can develop specific voluntary measures to support older people.

This first dividing line between the different territorial levels in the governance of the elderly sector has been reshaped by two recent laws. The first in 2004, a law on solidarity and loss of autonomy, which introduced the CNSA (the national solidarity fund for autonomy), a new national institution responsible for funding and implementing policy measures aimed at older and disabled people. The second, in 2009, named “Hospital, Patients, Health Territories” Act, which created a new regional institution representative of central government – the ARS (regional health agencies). Encompassing all existing regional and local health administrations, these regional health agencies extended traditionally health-sector-only intervention to the social care sector.

### Funding of the system

The funding of the French LTC policy is complex (Vasselle 2008, Charpin et al. 2011, Fragonard 2011). It combines social security funds (social contributions) and local authorities’ taxes. According to Renoux et al. (2014), taking into account the social care dimension (€9.7 billion), health insurance expenditure (€11 billion), and accommodation in institutions (€7.5 billion), in 2011 the overall cost of public expenditure on LTC policies represented €21 billion – i.e. 1.05% of GDP. Including household contributions, in particular

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<sup>4</sup> A specific French sector in tandem with the health and social sectors, whereas English only distinguishes “health care” and “social care” sectors.

for the cost of accommodation in residential homes, estimated at €7 billion, the total budget on this policy comes to around €28 billion – i.e. 1.41% of GDP.

## “Community care” scheme to support elderly people and their families

A first category concerns services in the social and health sectors that propose solutions for both home-based care and residential care (box 2). A specific formal care work sector has developed in France to provide professional care in the home and in institutions.

### Box 2: Home-based and residential services for elderly people

- (1) **Home care nursing services** (Services de soins infirmiers à domicile, SSIAD): 117,093 places in 2014
- (2) **Home help and support services** (Services d'aide et d'accompagnement à domicile, SAAD) which include non-profit organizations and public social care services. According to the 2011 INSEE employment survey, there were 535,000 home care workers in 2011.
- (3) **Private companies** in the personal services sector: these require quality certification. Their prices are established freely and subject to a contract drawn up with the cared-for person. In 2008, they represented only 4% of social care workers for elderly people (Marquier 2010b).
- (4) **Housing facilities** (foyer-logement): social establishments, often run by municipalities. These facilities accommodate old people who are mostly autonomous in small adapted apartments to minimize the risks (of fall, in particular). The development of this type of accommodation is a priority of the 2015 “Act on adapting society to an ageing population”.
- (5) **Nursing homes** (établissements d'hébergement pour personnes âgées dépendantes, EHPAD, and private nursing homes): in 2015, they cared for 10% of elderly people aged 75 or more and 1/3 of those aged 90 or more. The average cost of EHPAD accommodation varies from €51 to €71 per day (Muller, 2017). A specific allowance (social assistance for accommodation – ASH) may be allocated to the poorest residents to help them pay for the accommodation part.
- (7) **Day care centres** and temporary accommodation concern 4% of elderly people cared for.

According to the DREES survey (Muller, 2017), in 2015 728,000 elderly people lived in residential care, which represented an increase of 4.8% compared to 2011. The recent CARE survey (Brunel and Carrère 2017) estimates the number of elderly people living at home between 0.4 million (including only high-level dependency cases) and 1.5 million (also including mid-level dependency cases).

A second category of measures is related to ‘coordination’ and/or ‘integration’. These measures developed to facilitate relations between the different professional actors - health and social care workers – and institutional actors involved in LTC policy in France. In this perspective, the “gerontological networks” (*réseaux gérontologiques*) were created in 1996. More recently, three different schemes have been introduced in order to facilitate continuity of care: the MAIA (method for integrated care in the sector of autonomy – *Méthode d'Action pour l'Intégration d'aide et de soin dans le champ de l'Autonomie*), the PAERPA (elderly people at risk of loss of autonomy – *Personnes âgées en risque de perte d'autonomie*) and the PTA (territorial support platforms for coordination – *Plateformes territoriales d'appui*).

Defined at the national level and devised to support health and social care professionals in their coordination tasks, the three schemes have different focuses, i.e. prevention, complex situations and a health and/or social care perspective. Coordination is also needed to help elderly people and their families identify existing support and locate the information they need. Local information and coordination centres (*Centres locaux d'information et de coordination – CLIC*) were created to this end in the early 2000s.

**A last category of schemes concerns informal carers.** Although families are no longer left alone to cope with their caring responsibilities, public support is not a substitute for family care. According to the HSA survey (Soullier 2011), 48% of the cared-for are supported by an informal carer only, 20% by professionals only and 32% by both professionals and informal carers. In other words, 8 older cared-for people out of 10 receive at least some support from their relative(s). 44% of these informal carers of elderly (more than 60 year old) are spouses. In 20% of the cases, the carer is a daughter, in 13% a son, in 13% a mother or a father (Weber, 2015).

The possibility to outsource a share of the caring activities has entailed the necessity to coordinate the different professionals and the development of informal carers as “care managers” (Da Roit, Le Bihan, 2011). In a context of spending cuts that make the creation of new services difficult, the importance of the role of informal carers – relatives but also neighbours or friends – who deliver care and/or act as care managers of the organization set-up was recognized in the 2015 Act on adapting society to an ageing population. In France, public intervention aimed at informal carers is based on measures to support carers in their activities rather than financial compensation. Besides, although the APA can be used to pay a relative (except the spouse), this solution remains marginal (8% of beneficiaries in 2016).

- Carer leaves: concern both elderly and disabled people.

**Table 2: Carer leaves**

Leave	Description	Duration	Payment level	Eligibility conditions	Flexibility
Carer Leave	To care for relatives with significant loss of autonomy	3 months, renewable up to one year	Unpaid	To have worked at least 2 years	Can be used for a part-time period
Family Solidarity Leave	To assist a dying relative	3 months, renewable once	Unpaid but daily allowance (€55/day max 21 days)	Granted to all employees	Can be used for a part-time period

- A right to respite was introduced in the 2015 Act on adapting society to an ageing population: max €500/year
- Training has been available to informal carers since 2009 (2009 Health Law)
- Information services: a national web platform was created in 2013; Local information and coordination centres (CLIC) also give advice to families.
- Respite platforms: propose advice and solutions to the cared-for and their carers.

## **The Act on adapting society to an ageing population**

The 2015 Act on adapting society to an ageing population marks a turning point in the conception of LTC policy. It attempts to move away from a compensating and medical approach to old age, focused on the notion of dependency, which dates back to the 1990s towards a more preventive orientation, including the notion of “healthy ageing” (Delaunay, 2017). It is based on three pillars: (1) Anticipating loss of autonomy, prevention and combating isolation among old people (€185 million in 2017); (2) Adapting society to ageing, which includes the launch of a plan to adapt 80,000 private housing units by 2017; renovate residence-accommodation (foyers logements), renamed ‘autonomy residences’ (€84 million in 2017); (3) Supporting older people facing loss of autonomy, with a priority given to home-based care (€460 million in 2017).

## **Main long-term care challenges in France**

### **Access and adequacy challenge:**

Despite the increased capacity of nursing services, temporary housing units and homes for elderly dependent people (6.5% increase in places from 2011 to 2015), several analyses have identified a problem in accessing services (Court of Auditors 2014, 2016). They indicate three main reasons:

- The offer of services lacks transparency which means that users find it difficult to identify the most appropriate solution.
- The cost of social care services. Although health services are financially covered by the health insurance system, families are often faced with paying considerable additional costs for social care services. In residential care homes, the average remaining cost to be met by residents is estimated at between €1500 and €1750 per month (excluding social housing benefit for the poorest); in the home, APA beneficiaries pay on average €80 per month from their care plan (Fizzala, 2016).
- Territorial disparities. Although national legislation exists, measures are carried out locally by *département* councils and regional health agencies (ARS), with important territorial variations. Rural areas in particular offer fewer in-home care services and nursing services than urban areas.

### **Quality challenge:**

In France, the development of a specific care work sector has two main objectives: to support elderly and disabled people and reduce unemployment through the development of a new professional activity sector. These two objectives have proved contradictory, as the quantitative dimension of the second objective is not always matched with quality (Le Bihan, Sopadzhiyan, 2018). The elderly care work sector is part of the larger sector of “personal services” (*services à la personne*), which focuses on the volume of workers and includes any person providing services to individuals. Although a specific diploma was created at the end of the 1980s (reformed in 2002 and 2016 to improve training), home-based care is still characterized by a low level of care worker training. According to statistics (Marquier, 2010), 62 per cent of care workers have no diploma from either the health or social sector.

The quality of residential care is currently being questioned. Despite an increase in the number of residents, staff ratios for care remained the same from 2011 to 2015. Combined with a pricing reform that is complex to put in place, nursing homes currently face considerable difficulties. Strikes have been organized since the end of 2017 and the situation seems deteriorating.

#### **Employment challenge:**

This challenge is primarily related to the work-life balance issue. The HSA survey (2008) carried out by DREES (Directorate for Research, Surveys, Evaluation and Statistics) estimated that 4.3 million carers regularly help one or more relative over 60 (Soullier, 2011). These carers are aged 58 on average and are most frequently women (they represent 57% of carers of older people, but the proportion increases with the level of dependency of the cared-for). The survey also shows that 46% of carers are retired, 39% have a job, 6% are unemployed and 9% do not work. Care investment has an impact on work in terms of stress and tiredness. 11% of carers have reorganized their professional lives by reducing their work hours, resorting to sick leave or changing jobs.

Although there are no specific data on how many working carers take advantage of carer leaves to achieve a satisfactory work-life balance, a recent survey (Sirven et al., 2015) suggested very low-take up of this type of leave, at only 7% of interviewees. Most carers (between 50% and 80%) were unfamiliar with the leave provisions. In fact, carers tend to use standard leave (sick leave) or even annual leave, rather than specific carer leaves, which is either unpaid or with a low allowance.

The second issue is the employment situation of professional care workers. This is characterized by precarious working conditions and insufficient training, which explains why the sector remains unattractive. The majority of care workers are employed on a permanent contract, which can appear as a secure form of employment. However, this employment stability is only apparent because of the high prevalence of part-time work and situations in which a care worker has several employers (Devetter and Lefebvre, 2015). Care service work still does not provide full-time work, with fewer than 30 per cent of home care workers employed full time (Marquier, 2010). The average length of the working week is 26.1 hours over 4.9 days, with home care workers attending to 6.5 different people in one week – 5.4 of whom are elderly. The average wage is €832 per month, but monthly earnings vary significantly when care workers are employed full time (€1190<sup>5</sup>) or part time (€717), depending also on whether the structure they belong to is public or private (Nahon, 2014).

#### **Financial sustainability challenge:**

Four main orientations can be identified, with a stress on the involvement of local actors.

- Improving coordination of the existing schemes, organizations, institutions and professionals has been high on the political agenda during the last decade.
- Developing prevention as announced in the 2015 Act on adapting society to an ageing population.

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<sup>5</sup> . Which corresponds to the minimum wage: €1100 per month.



- Using technological solutions: although investment in new technologies as a solution to support elderly people and their family is recent in France (end of 2000s), it is currently presented as a priority. The definition of what is referred to as the ‘silver economy’ sector encompasses a broad spectrum, from the most sophisticated safety technologies and robotics to the simplest technical aids and remote assistance services for old peoples’ housing and mobility. It is presented as a support for home-based care that will also impact growth, industrial development and employment.
- The final question, which cuts across several areas and constitutes the weak point of the 2015 Act, is the issue of funding the proposed policy. The €700-million budget per year is no doubt highly insufficient. In the mid-term, given the predicted demographic changes, the financing principles of the LTC sector therefore remains open. The possibility of creating a 5<sup>th</sup> social security branch, which first arose in the 1990s, has come up again. The government, aware of the difficulties of creating a new user contribution, is putting a greater accent on prevention, thus anticipating and reducing the costs of dependency.

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