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Quality and cost-effectiveness in long-term care and dependency prevention



COUNTRY REPORT

France

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– Ehesp / Arenes

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The long-term care sector in France

If current demographic trends continue, 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. This demographic evolution, which is due to increased life expectancy combined with societal changes (in particular the care deficit caused by greater participation of women in the labour market) and to the baby-boomers' arrival at old age, makes loss of autonomy a crucial issue for social and health policies in France.

In France, separate policies exist regarding disabled people – adult and children – on the one hand and older people (from 60 years) in need of care on the other hand. Although the creation of a national solidarity fund for autonomy (see Box 1) – Caisse Nationale de Solidarité à l'Autonomie, CNSA – which serves both sectors indicates some progress, to date insufficient progress has been made in the direction of a common policy sector for disabled and elderly people.

While home-based care and residential care for elderly people have developed since the 1960s, the definition of a specific LTC policy or, to use the French terminology in that period, a policy towards 'dependent elderly people' really emerged at the end of the 1980s and during the 1990s. This notion of dependency, defined as 'a state in which a person finds it impossible to carry out essential everyday tasks without the help of a third party', has been at the heart of French LTC policy and is now being put into question by the more global approach to long-term care issues put forward in the recent 'Act on adapting society to an ageing population' (December 2015). The introduction below describes the various measures and types of funding linked to elderly care, and discusses the 2015 Act on Adapting society to an ageing population, which proposes a new approach to old age.

LTC policy in France: diverse funding and policy measures

Public intervention is diverse in the sector of elderly care (Le Bihan and Martin 2010). It comprises a series of policy measures aimed at developing

Box 1: Caisse nationale de solidarité pour l'autonomie (CNSA) – National fund for autonomy

The creation of the CNSA was one of the government's responses following the devastating heat wave of the summer of 2003. CNSA financial resources are devoted to the dependency sector in its wider sense, i.e. both elderly and disabled people. CNSA acts as an equalizing fund, sharing out allocations to finance care from medico-social establishments and services, and covers some of the expenses of services for older and disabled people, managed by the départements.

Funds are based on:

- (1) Transfer of a share of funds from the sickness branch of the social security system (€18 billion in 2016)
- (2) The fund's own resources, amounting to €4.3 billion in 2016, which derive from:
 - a tax: 0.1 % of the CSG (general social contribution) which represented €1.3 billion in 2016
 - a solidarity contribution for autonomy – contribution solidarité autonomie – created in 2004, based on employer and employee revenues (compensation for overtime, so-called 'solidarity day') which amounted to €2.3 billion in 2016
 - an additional contribution for independent living – contribution additionnelle de solidarité pour l'autonomie (CASA) – introduced in 2013, which represented €0.7 billion in 2016

home-based care or institutional care crossing different sectors, such as social care, healthcare, old age, family and employment. It involves different territorial levels at different degrees and in different ways: at territorial level with the *départements* (local administrative divisions), which are at the front line of social policy in France, as well as municipalities which are free to develop policy measures in this sector; and at national level through organizations like the *Caisse Nationale de Solidarité pour l'Autonomie* (national fund for autonomy, CNSA – see Box 1) and the regional health agencies – *Agences régionales de Santé* (ARS) created in 2009 and in charge of the implementation of policies defined by the government.

Box 2: l'Allocation personnalisée d'autonomie (personal allowance for autonomy, APA)

The APA is a financial benefit created by the Act of 20 July 2001 (which reformed the previous Specific Dependency Allowance), paid by the département to any person aged 60 or over who needs assistance to accomplish daily living activities or needs to be continuously watched over.

It is paid either at home to finance a 'care plan' devised for elderly people by professionals from the département (mostly personal care, but also technical support or home alterations) according to the level of dependency and the needs of the elderly people and after an assessment of their situation by a multidisciplinary team; or in residential homes.

It is not means-tested, but takes the person's income into account to determine how much the user should contribute (to the funding of the care plan). Each level of dependency gives access to a maximum amount: level 1: €1,713; level 2: €1,375; level 3: € 993; level 4: €662

Under a monthly income of €800 recipients do not contribute to the funding of the care plan; if they have incomes of €2945 or more recipients contribute 90% of the funding.

Defined as 'a state in which a person finds it impossible to carry out essential everyday tasks without the help of a third party', the French approach to dependency applies an age criterion (above and below 60) and so makes a distinction between the worlds of the disabled and the elderly. It is assessed according to a national scale called AGGIR, which identifies levels of dependency from 1 (the highest) to 6. The social and family environment is also clearly a crucial variable since it directly influences the old person's needs. In addition, dependency is judged as having a negative connotation when used to describe old people, with a preference today for the notion of 'loss of autonomy'.

Long-term care policy in France is based on a financial benefit, introduced in the late 1990s as the Specific Allowance for Dependency, which aims to help 'dependent' older people identify their needs and pay for care services. This benefit, now called the *Allocation personnalisée d'autonomie* (personal

allowance for autonomy, APA – see Box 2), represents over €5 billion, of which 70% comes from the département and 30% from the National Solidarity Fund for Autonomy (CNSA, see Box 1).

Funding the so-called dependency policy has been the subject of debate regarding its scope. In its broader sense¹, including not just social care financed by the allowance (APA) and based on taxation, but also the health insurance system, the overall cost of public expenditure for policies towards older people is between €21 billion and to €24 billion – i.e. 1% to 1.3% of GDP. Including household contributions, in particular for the cost of accommodation in older people's homes, estimated at €7 billion, expenditure on policies towards elderly people comes to around €28 billion. Four types of measures can be identified in the elderly care sector. A first category concerns services in the social and health sectors that allow elderly people to remain at home or move into an institution. Home-based care comes under the responsibility of home care nursing services (*Services de soins infirmiers à domicile, SSIAD*) and home help and support services (*Services d'aide et d'accompagnement à domicile, SAAD*), which are considered as highly insufficient (box 3). Institutions for older people are of three types: nursing homes (called *établissements d'hébergement pour personnes âgées dépendantes, EHPAD* (accommodation establishments for dependent old people), housing facilities, and long-term care units in hospitals for highly dependent old people (see Box 3).

¹ For details concerning the history and characteristics of LTC sector see the following reports: Vasselle A., 'Rapport d'information sur la prise en charge de la dépendance et la création du cinquième risque'. Senate report, 2008; Vasselle A., 'Rapport d'information sur la prise en charge de la dépendance et la création du cinquième risque.' Senate Report, January 2011. Reports of working groups gathered as part of the debate launched by the government in 2011: 'Enjeux démographiques et financiers de la dépendance, Société et vieillissement, Accueil et accompagnement des personnes âgées en perte d'autonomie, Stratégie pour la couverture de la dépendance des personnes âgées'; Report by the Centre for Strategic Analysis: 'Les défis de l'accompagnement au grand âge. Perspectives internationales pour éclairer le débat national sur la dépendance'.

Box 3: Services available in the home and in institutions for dependent older people

1. Home care nursing services (SSIAD): 117,093 places in 2014

2. Two categories of home help and support services (SAAD) work with vulnerable people in need of care (both elderly and disabled people):

- Social care workers in non-profit or public social care sector, sometimes managed by local authorities (municipalities or départements). According to the 2011 employment survey performed by the INSEE (National Institute of Statistics and Economic Studies), there were 535,000 home care workers in 2011.
- Private companies in the personal services sector (Act of 26 July 2005) must have received quality certification. Their prices are freely set and subject to a contract drawn up with the cared-for person. In 2008, they represent only 4% of the social care workers of elderly people (Marquier 2010b).

3. Housing facilities (foyers logements): social establishments, often run by municipalities. These facilities accommodate old people who are mostly autonomous in small apartments adapted to minimize the risks of falls or accidents. Trained staff (nurses, caretakers) are constantly present and there are alarm and surveillance systems.

4. Nursing homes (EHPAD): there are 10,481 EHPADs offering 719,810 places. The average cost of EHPAD accommodation varies from €51 to €71 per day.

A second category of measures are related to ‘coordination’ and/or ‘integration’ measures which have developed to connect all national and territorial professional and institutional stakeholders involved in the care of elderly people. We can mention the gerontological networks created in 1996, as well as the *Centre locaux d’information et de coordination* (CLIC) created in the early 2000s to advise old people and their families. More recently, three different schemes – 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*) – were introduced in order to facilitate continuity of care. Based on the idea of supporting health and social care professionals in their coordination tasks, the three schemes differ in the focus they put on prevention, on complex situations or on the health and/or social care perspective they develop (see below).

The last category of public measures comprises the specific plans and programmes set up by successive governments, e.g. the solidarity plan for the very old², or plans that target care for those with Alzheimer’s Disease (three different Alzheimer Plans from 2001 to 2012) and other neurodegenerative diseases (2014-2019).

Along with these public measures, France has the biggest private insurance market in Europe (although still relatively small – between 3 and 5 million insured parties³), when considering the potential of 14 million people aged 60 or older. Unlike the United States, where measures exist to reimburse sums paid out to deal with dependency issues, the French policies, e.g. protection policies, dependency savings contracts and complementary health contracts, offer a fixed amount of between €300 and €500 per month, making it easier to manage and monitor.

Considering these different policy measures, one can consider that there is in France a public intervention in the sector of elderly care. Yet, although families are no longer left alone to cope with their caring responsibilities, public support is not a substitute for family care. Conceived as a complement to family care, and presented as a financial support to externalize part of the caring

² The Old Age Solidarity plan 2007-2012 had several objectives: to increase the number of care places in accommodation facilities; to increase the number of medical places (by gradual modification of the way care tariffs are set); and to develop medical services in the home (with the aim of increasing the proportion of care in the home).

³ Estimates vary depending on the source and type of contract considered (see the Vasselle Reports).

activities and buy services, the cash-for-care scheme solution introduced at the end of the 1990s' implies significant investment on the part of family carers as case managers. The recent evolutions in the elderly care sector confirm the importance of the family intervention.

Recent developments in the French LTC sector

Published on 29 December 2015, the *Act on adapting society to an ageing population* came into force on 1 January 2016. This legislation attempts to anticipate the consequences of an ageing population by meeting the needs of old people in terms of housing, transport, social and civic life, in addition to care delivered at old age, in situations of loss of autonomy (Le Bihan, 2016). It is based on three pillars:

- (1) *Anticipating loss of autonomy*, which comprises financing action on 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, renamed 'autonomy residences'; and create civil volunteering for seniors (€84 million in 2017);
- (3) *Support for older people facing loss of autonomy*, which focuses on home-based care (€460 million in 2017). The objective is both to contain the cost of the care and to satisfy the wish of many elderly people to continue living at home for as long as possible. Indeed, more than 90% of people aged 75 and over live at home, and three out of four aged over 85 (FNORS 2009). It is estimated that in France, 75% of the dependent elderly in need of care receive support from relatives (Soullier, 2011), who on average spend twice as much time with their parents than professionals. Key to this support is a reform of the 'personal allowance for autonomy' (APA: see box 2). The intention is to allow elderly people to make free choices by facilitating their preference to stay at home. It also includes a financial increase of this benefit and funding for

introducing new technology into old people's daily lives and for training social carers. Furthermore, it includes the creation of a 'right to respite' for family carers.

In addition to these three pillars, the accent is on the cross-cutting issue of coordinating the various stakeholders (institutional, professional and political) concerned with elderly care.

The law adopted in December 2015 marks a turning point in policy on old people in need of care, or at least in the conception of policy in this sector. It attempts to move away from a medico-social approach to old age, focused on the notion of dependency, which dates back to the 1990s. In a climate of spending cuts, the left-wing government has drawn up an ambitious law that tackles the issue of ageing in a comprehensive manner, integrating the notions of growing old comfortably and protection for old people losing their autonomy (Delaunay, 2017). The new law's concern to include the different aspects of old age illustrates this comprehensive dimension. The objective to encourage volunteer work among old people and inter-generational interaction also moves in this direction. Overall, the text takes a positive stance on old age, describing it not as a disease, but a period of life subject to frailties, and consequently risks, which need to be considered. The law affirms that policies on age must take into account the social connection between older people and the rest of society and recognize the trajectory of their lives, in particular their desire to remain living at home.

In this same perspective of a comprehensive approach to ageing issues, the new law considers the needs of informal carers, who are seen as the lynchpin of support for old people losing their autonomy. Statistics indicate that 4.3 million people give support to a relative aged over 60 (DREES HSA, 2008). Although this recognition of the investment made by family carers is addressed at length in the document annexed to the law, in concrete terms it remains very limited, since the text only includes the right to take a break by means of

an annual €500 lump sum paid to carers to finance day care or temporary accommodation, and a focus on the existing unpaid carers' leave.

The question of the funding of the law leads to a major criticism expressed by health and social professionals as well as by the right-wing opposition and social partners, that the budget allocated to the implementation of the law is insufficient. The amount of CASA is not enough to meet all the targets announced and the concrete measures taken to achieve the different objectives are viewed as limited. The increase in the existing benefit (APA) is also judged to be insufficient. We might therefore question whether the adopted law has the means to match its ambitions.

Another issue relates to the comprehensive approach itself. Can it really be comprehensive when a significant aspect of support for elderly people – institutional care – is ignored? The law only deals with home based care and, for financial reasons, the announced text on residential care has been abandoned. Moreover, can the law claim to take a comprehensive approach to the question of autonomy when it targets the over-60s? On the contrary, the text contributes to the marked boundary which already exists between the sector of disability and the sector of elderly care. The creation of a single broad sector of 'autonomy', which would include all people whatever their age, supported by health and social professionals in the old people's sector would mean that current benefits for disabled people, which are financially much more generous, would be extended to the old people's sector.

The implementation of the Act on adapting society to an ageing population has begun with the financial review of the existing allowance (APA) from March 2016, the introduction of an allowance to finance respite for a relative providing care (€500/year) and the concrete organization of the main coordination scheme introduced by the law: the 'Funders' conference for prevention of elderly people's loss of autonomy' (*Conférence des financeurs de la*

prevention de la perte d'autonomie) which gather, at the level of the département, the main policy and institutional actors in the sector of elderly care in order to identify and coordinate their actions.

In the current restrictive financial economic context, two main issues can be identified for the implementation process of the Act on adapting society to an ageing population:

The articulation between family care and public support, with the ambiguity represented by the development of policy measures and schemes targeted towards carers. Although it contributes to facilitate the investment as carers of one's relatives, does it also reveal the state's disengagement from the elderly care sector? Does it correspond to a 'supported familialism' type of intervention (Saraceno, 2010)?

The public investment in coordination and integration measures in order to facilitate the continuity of care for elderly people and their families.

The ageing of the population, the challenge of chronic diseases and the need to adapt the health system to these new challenges are also main issues of the recent health law – Act on modernizing our health system of January 2016 (*Loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé*). It reaffirms the policy orientations of the previous health laws and of the 2013 national health strategy. Yet, the measures it develops adopt a larger perspective encompassing all periods of life, not only older patients. The accent put on prevention is also very strong (part 1 of the law) as well as the need of coordination of primary and hospital care (part 2 of the law, concerning the necessity to facilitate health pathways in everyday life). The concept of health pathways is central to this objective of coordination and appears to be framing the current policy debates on this issue. It has been defined in the Article 1, L.1411-1 of the same law as follows: '[the] health pathways aim at guaranteeing continuity, accessibility, quality,

security and efficiency in the [health] care provided to the population in collaboration with the users and the local and other territorial authorities, through the coordination of the health, social and medico-social

sectors, and by taking into account each territory's geographic, demographic and seasonal specificities in order to achieve territorial equity.'

Theme 2: What interventions could reduce dependency cost-effectively?

Context: prevention and coordination on the French political agenda

As mentioned in the introduction to this report, prevention is a key word of both the recent Health Law and the Act on adapting society to an aging population. Before analysing the recent measures which have been implemented, particularly with the development at the level of the départements of the 'Funders Conference' introduced by the Act on adapting society to an aging population, it is important to explain how and when prevention, and the institutional coordination it implies, became issues in the French LTC sector.

A first period can be identified, which corresponds to the first decade of the 2000s. The idea of prevention emerged in the LTC sector with a first National Programme for Healthy Ageing in 2003, which continued to 2005 and was extended in 2007 with the National Plan for Healthy Ageing. The plan is part of the international Healthy Ageing project which was launched by the EU in 2004. Based on prevention, the plan develops a comprehensive approach through a series of measures aiming at promoting 'successful ageing'. Taking into account both individual health and social relations (Aquino, 2008) it concerned seniors from 55 to 75 years old and was organized around diverse issues (prevention of complications in chronic diseases, promotion of positive health behaviours, improvement of the individual and collective environment, the development of seniors' social and cultural participation, the reinforcement of intergenerational relations) organized around nine different axes.

The next period, 2010–2015, is first characterized by major changes in the health sector at two different levels. At the organizational level, the 2009 Health Law created a new institutional actor – the regional health agencies (agence régionale de santé – ARS). Representative of the central government and comprising all pre-existing regional and local health administrations, these new agencies extended traditionally health-sector-only intervention to the social care sector. The introduction of a single institutional actor dealing with both dimensions of care was a major objective of the law. However, since the départements maintained their leading role in the social policy field, the need for collaboration between the two institutional levels became a major challenge.

At the policy level, the recent 2016 Health Law is organized around three main axes, with the first one devoted to the reinforcement of prevention and promotion in the health sector. This marks an evolution of the concept of health policy, previously focused on acute care, to a more comprehensive approach to health issues. The law underlines the necessity to anticipate problems in a context of increased life expectancy and prevalence of chronic diseases.

As regards the elderly care sector more specifically, the 2010–2015 period is marked by the announcement of the coming Act on adapting society to an ageing population and by the production of reports to prepare this legislation (see Table 1). Three reports were delivered at the beginning of 2013, with propositions on what has been announced as the three pillars of the coming law: anticipation of loss of autonomy, adaptation of society, and care of elderly people.

Table 1: Sequence of the development of the prevention policy in the sector of LTC

2003	National Programme on Healthy Ageing (programme national ‘Bien Vieillir’)
2006	Solidarity Old Age Programme (Programme solidarité grand âge)
2007–2009	National Plan on Healthy Ageing (Plan national bien vieillir)
2010–2011	Evaluation of the National Plan on Healthy Ageing
2012	French speaking network of ‘old age friendly cities’ (réseau francophone des villes amies des aînés) Announcement of a coming law to reform LTC policy: the ‘Act on adapting society to an ageing population’ and creation of a specific committee (the Ages committee) gathering experts in charge of the development of the Law
Early 2013	Three reports on old age delivered to the French ministry of health and social affairs to contribute to the announced Act on adapting society to an ageing population. Aquino J.P., ‘Report on the Act on adapting society to an ageing population – Anticipating to maintain autonomy: a social challenge’ [Rapport sur la loi d’adaptation de la société au Vieillissement – Anticiper pour une autonomie préservée: un enjeu de société], ministère des Affaires sociales, 2013. Broussy L., ‘Adapting society to ageing – France: Year Zero’ [L’adaptation de la société au vieillissement – France: année zéro], ministère des affaires sociales, 2013. Pinville M., ‘Report on the Act on adapting society to an ageing population’ [Rapport sur le projet de loi relatif à l’adaptation de la société au vieillissement], ministère des affaires sociales, 2013.
September 2015	Presentation of the National Action Plan for the Prevention of Loss of Autonomy
December 2015	Vote of the Act on adapting society to an ageing population and implementation of the ‘Funders’ Conference to prevent elderly people’s loss of autonomy’

To complete this picture of the development of prevention in the sector of elderly care, the role of municipalities through the creation of the French speaking network of ‘Age Friendly Cities’ (*Réseau francophone des villes amies des aînés*), must be mentioned. Created in 2012 and part of the OMS programme, it gathers 38 members and engages cities to become more age friendly by adapting the social and physical environment to old people and strengthen their feeling of belonging.

Recent developments

The ‘National action plan for the prevention of loss of autonomy’ [*Plan national d’action de prévention de la perte d’autonomie*] was presented in

September 2015. Extending the proposals of the Aquino report, the plan constitutes the national framework of the ‘Funders’ conference to prevent elderly people’s loss of autonomy’ [*Conférence des financeurs de la prévention de la perte d’autonomie des personnes âgées*] created by the 2015 Act on adapting society to to an ageing population. It is based on two main principles (see National Action Plan for the Prevention of Loss of Autonomy, 2015, p. 11):

- The development of ‘comprehensive prevention’ defined as the active and responsible management of the ‘capital of autonomy’ of each person or group of people.

- The devolution of the implementation to local actors on the ground within a specific frame and precise objectives.

The plan is structured around six axes considering the whole life of the person, not only when the difficulties related to ageing occur: improve health and autonomy determinants, prevent avoidable loss of autonomy, avoid the worsening of situations with existing incapacities, reduce social and territorial health inequalities, train professionals in prevention of loss of autonomy and develop research and assessment procedures.

One of the main measures of the anticipation section of the Act on adapting society to an ageing population, the 'Funders' conference to prevent elderly people's loss of autonomy' constitutes a new space for the development of institutional coordination. As stated in the National Action Plan for the Prevention of Loss of Autonomy, it is managed at the local level, under the responsibility of the *département*. It has been introduced to create a territorial dynamic in order to facilitate the development of prevention in the sector of elderly care. It aims at gathering the various actors implied at the local level in preventive actions and facilitate the discussion as well as joint decision-making in order to define a common and coordinated policy strategy for the funding of the different actions.

Chaired by the departmental council's president and co-chaired by the managing director of the regional health agency (ARS), it also links the other local institutional actors contributing to the development of prevention actions in the elderly care field: representatives from the other local territorial authorities (such as municipalities or groups of municipalities), from the national housing agency's local delegations and from the basic old-age and health insurance institutions, as well as from the old-age and health insurance funds.

To complete its mission, the funders' conference takes stock of the different initiatives existing in the territory and provides an assessment of the needs of people aged 60 years and older related to

prevention. The common programme in favour of the prevention of elderly peoples' loss of autonomy must include six different fields: improvement in access to services and individual technical support; allocation of a fixed amount to the new 'autonomy homes' created by the Act on adapting society to an ageing population; coordination and support for prevention initiatives from social care and polyvalent health and social care services; support to informal carers; and development of collective prevention actions.

At the national level, the new scheme is managed by the CNSA and the ministry of social affairs and health. Each conference provides an annual activity report to the CNSA.

Piloted in 2015 in 24 territories, it has been extended to the whole country with the implementation of the Act on adapting society to an ageing population. The funding of this new measure is based on two sources: a specific budget allocated to the Funders' Conference (see 'anticipation' section of the Act on adapting society to an ageing population) representing €127 million in 2016 and €180 in 2017; and the funds invested by the different partners involved in the conference to finance the various measures.

The Act on adapting society to an ageing population proposes other measures to anticipate elderly peoples' loss of autonomy. They concern the development of new technologies and will be presented in the chapter dealing with this issue.

Effectiveness of the policy measures

It is difficult to assess the impact of the different measures which have been implemented since the beginning of 2000s. In 2010, an assessment of the National Action Plan was carried out but as explained by the experts (Cases et al., 2011, Ministère de la santé et des sports, 2010) a main difficulty concerned the assessment process itself, as the plan did not anticipate one. It did not define any indicators or scoreboards and it was impossible to estimate the concrete impact of the different

measures on the evolution of ageing and on elderly care policy. Nonetheless, the report identifies problems which should be avoided in the future. Underfunding was a crucial problem according to the evaluators: unlike the 2006 Solidarity Old Age Programme which had funding of €2.3 billion over five years, the budget allocated to the National Plan for Healthy Ageing was low (€168 million for three years). The governance of the plan was also considered insufficient as there was no unique senior accountable owner to manage it and no formalized inter-ministerial coordination, which constitutes a key component of the success of such policy.

Finally, the heterogeneity of measures implemented – covering nutrition, sport, therapies, retirement, intergenerational solidarity and innovation was underlined. The assessment report concluded that the plan did not have either the human or the financial means to reach its objectives, an indication of the place given to prevention in the first decade of the 2000s. The experts concluded that the development of a healthy ageing policy based on prevention needed a deep change of mentality and the implementation of a comprehensive health policy with a focus on prevention and not only on therapies and acute care.

The recent Health Law as well as the Act on Adapting Society to an Ageing Population appear to go in the recommended direction. Both dedicate a

specific section to prevention and present it as a key component of the policy strategy. In addition, the current National Action Plan for the Prevention of Loss of Autonomy takes assessment procedures into account. Finally, the implementation of the Funders conference to prevent elderly people's loss of autonomy, which is a key measure of the prevention policy, started in 2015 with a pilot phase in 24 territories, before its expansion to the other 81 départements. This process has enabled the CNSA, which is responsible for the follow up of the scheme at the national level, to develop a precise technical guide to support départements in the development of the scheme (Technical Guide for the 'Funders' Conference to prevent elderly people's loss of autonomy', CNSA, 2016, 76 pages).

The measures are recent and we do not have the necessary distance to assess their impact. Even so, some questions can be raised. For instance, though focused on prevention and on elderly care the 'Funders' conference to prevent elderly peoples' loss of autonomy' has in common with other existing schemes the creation of a more or less formalized space to facilitate discussion and to coordinate the actions of the various actors involved in health and social care. As such, it can be added to a range of other schemes having a similar objective, but in different areas, such as the MAIA scheme and its strategic meetings in the field of autonomy (see below).

Theme 3: What interventions and policy measures can support unpaid carers effectively?

Context: a major policy issue

France is a country with a strong family tradition, which has evolved towards a mixed welfare system with the development of home-based services and residential care and where unpaid informal carers have always played an essential role (Le Bihan, 2012).

There is a range of research available on carers, giving information on the characteristics of those

who support their relatives in need of care. Some concerns old people in need of care specifically and other research looks at more generally people with disabilities (see for example Weber, 2010; Association des Paralysés de France (APF), 2013; Sirven et al., 2015). The HSA survey led by the Direction of Research, Studies, Evaluation and Statistics of the French Ministry of Social Affairs (Direction de la recherche, des études, de

l'évaluation et des statistiques (Drees) estimated in 2008 that 4.3 million carers regularly help one or more family members over 60 (Soullier, 2011). These carers are aged 58 on average (27% are under 50, 26% between 50 and 59, 31% between 60 and 74 and 16% over 75 years old) and most frequently women⁴. Despite variations according to inquiries, figures show that men (partners or sons) make an appreciable and growing contribution to care (Bonnet et al. 2011).

The HSA survey also shows that 46% of carers are retired, 39% have a job, 6% are unemployed and 9% do not work (they may be at home or student). Therefore, when a high level of weekly hours of care is needed, achieving a work-life balance may be very difficult for carers (Fontaine, 2009, Domingo et Vérité, 2011). Only 2% of the carers who do not work report having stopped their professional activity because of their role as carers, which confirms qualitative analysis showing that work is often considered as an economic but also social psychological necessity for carers (Le Bihan and Martin 2006, Le Bihan et al. 2013). But it has an impact on work in terms of stress and tiredness. According to the HSA survey, 11% of the carers have reorganized their professional lives by reducing their hours of work, resorting to sick leave or by changing jobs.

Family and personal life is also directly impacted by the investment as carers (Le Bihan et Martin 2006,). In the HAS survey 20% of carers (of all ages) declared that they did not have enough time for themselves, 14% that they did not have enough time for their families, and 7% that their family relationships were under pressure because of care involvement (Soullier, 2012).

Based on the HSA survey, an analysis of the load felt by the carers of older people has been carried out (Soullier, 2012). It concerns 3.4 million carers who support in their daily life one old relative at home (excluding carers giving only financial or administrative support and not contributing to daily living tasks). Eight out of ten carers experience a light load and two out of ten a heavy load (which represents 690,000 carers). Two main factors contribute to this feeling of load: the importance of loss of autonomy and the diversity of the tasks performed as an informal carer. Adult children who work and care for an old parent are particularly concerned by these difficulties.

In a context of economic crisis, which makes it difficult to finance new services and benefits for older people, the issue of support to informal carers is high on the French policy agenda. The recent Act on adapting society to an ageing population (December 2015) has extended the term 'carer' to people outside the family. It recognizes the French term *proche aidant* (which is difficult to translate: *aidant* means 'carer' and *proche* refers to 'close friend') as follows: 'the following are considered as *proche aidants* (carers) of an old person: their spouse, the partner with whom they have concluded a civil solidarity pact, a cohabitant, a parent, or ally, defined as family carers, or a person living with them and with whom they maintain a close, stable relationship, who provides them with care regularly and frequently, in a non-professional capacity, to carry out all or part of the acts or activities of daily life.' (article 51).

The Act on adapting society to an ageing population has confirmed and extended the role of the National Solidarity Fund for Autonomy (CNSA) as the national agency in charge of the management and follow up of the elderly care policy. Concerning informal carers, the agency proposes the funding of training for carers, a support mission for the creation of the 'Funders' conference for the prevention of the elderly people loss of autonomy' (see below) and the development of a referential to define the needs of carers.

⁴ According to Soullier (2011), 54% of the informal carers are women. According to another survey (Haut conseil de la famille, *La place des familles dans la prise en charge de la dépendance des personnes âgées*, 16 juin 2011), focusing on the recipients of the Personal Allowance for Autonomy (which is delivered in situations of middle and high levels of dependency), 62% of the carers of elderly people receiving the APA are women.

Different issues can be raised according to the type of carers concerned: the need for respite, which applies to both partners and children who care for the older person, the difficulty of juggling work and care for children who care for their parent(s) and the recognition of a specific 'status' of carer. A variety of mechanisms and schemes that have a direct or indirect impact on the investment as a carer can be identified: care leave to enable a temporary withdrawal from the labour market; opportunities for part-time work; allowances to enable the partial outsourcing of caring activities to professional carers; the possibility of paying a family member using the allowances; and respite services. The analysis shows that, although they exist, measures to support carers of dependent relatives with a high level of needs remain insufficient.

Existing policy measures

Specific care leaves which concern both older and disabled people are presented in Table 2.

While they are not financially generous for the carers of dependent adults, leave periods underwent recent changes with the law on adapting society to an ageing population (approved in December 2015), aimed at extending the possibilities available to carers. Now called *Congé de proche aidant* (Carer's Leave), the Family Support Leave can be used for a part-time period.

Flexibility in the organization of working hours for carers who are in employment is another solution to facilitate work-family life balance (Knijn and Da Roit, 2013). In France, no legal obligation exists to provide flexible hours for family carers, but a 2005 law (Law of 11/02/2005) includes positive action in their favour to help them combine care and work with personalized working hours. This arrangement should allow working carers to choose the start and end times of their working days within time slots decided by the employer, provided that a certain number of hours are worked. The employed person can thus plan their working time.

Table 2. Carers' leave in France

	Family Support Leave (now called Carer's Leave)	Family Solidarity Leave
Description	To care for disabled relatives or members of family subject to important loss of autonomy.	To assist a dying relative
Duration	Three months, renewable up to one year for the whole career.	Three months, renewable once
Payment level	Unpaid	Unpaid but a daily allowance can be granted (see 1.3)
Eligibility conditions	Granted to employees who have worked at least two years for a company	Granted to all employees
Flexibility	Can also be a period of part-time work	Can also be a period of part-time work

Table 3: Cash benefits

	Personal Allowance for Autonomy (APA)	Daily support allowance	Right to Respite Allowance
Description	Delivered to the cared-for person (aged 60+) who can either pay a professional carer or an informal carer, except the spouse In the case of an informal carer, a salary is paid and the employed person benefits from all the social rights of an employee (social security, pension insurance, paid leave, etc.)	Paid as part of family solidarity leave	Aims to make it financially viable to find a temporary solution for the carer to find some respite by funding hours of care in the home, temporary accommodation or day care
Amount	Maximum amount according to level of dependency: level 1: max. €1,713 level 2: max. €1,375 level 3: max. €993 level 4: max. €662	Maximum 21 days: €55.15/day (€27.58 if the employee chooses part-time work rather than leave)	€500/year
Eligibility criteria	According to the level of dependency (level 1 to 4) of the cared-for person Universal but amount is adjusted according to level of income	Possible to combine part of the allowance with part-time work	Paid to carers of old people aged over 60 who are losing autonomy

Services to support informal carers have also developed in France since the beginning of the 2000s and they are becoming more and more important in the measures proposed to develop long-term care policy. Respite for carers is a first issue. As explained in the carers' guide (CNSA, 2014) for family carers, respite responds to their need for time, pause and relaxation. This right to respite is written into the Social and Family Action Code and establishes compensation for disabled people, consisting of a response to their needs and allowing 'disabled people's families to benefit from some respite' (art.L114-1-1). Solutions can take different forms, such as support in the home, itinerant night watch for a few days, (24 hours/24) holidays for the carer/cared-for pair and the family; temporary care in an institution, with or without

accommodation (day and/or night care). The funding of these respite solutions is a difficulty for carers and in view of this, a right for respite allowance has been created in the recent Law on adapting society to ageing (see Table 1).

Another issue is the information carers have about these various measures. One useful document is the Carers' Guide (*Guide des aidants*) produced by the National fund for autonomy. Various services in the elderly care system also provide information to carers and even offer training. The 'respite and support platforms' created under the 2008-2012 Alzheimer Plan, which offer carers and the cared-for temporary support to give them a chance to learn about the different existing measures also comes into this category. Local information centres for

older people (*Centres locaux d'information et de coordination*) have been existing since the 1990s'. Finally, training of carers is also developing, through the funding of the 2009 Health law, which has been confirmed in the recent Act on adapting society to an ageing population.

Effectiveness of the policy measures

As stated in recent reports (Gand et al., 2012; Eneis et CNSA, 2015; Le Bihan et Roussel, 2016) on the issue of unpaid carers, there are no relevant impact studies on the effectiveness of the policy measures which have been implemented to support informal carers.

The existing measures remain limited, particularly in situations where there are high levels of need. Recent specific measures introduced with the aim of facilitating work-life balance, such as carers' leave, are clearly insufficient and do not cover the range of situations and needs of informal carers. Existing forms of care leave give only limited opportunities to informal carers: they are unpaid; when there is an allowance the amount remains low; and they cannot be transferred from one day to another when an urgent situation arises (which is a main need of informal carers).

As far as the impact of carers' leave is concerned, there are no specific data on how many working carers take advantage of carers' leave to reach a satisfying work-life balance. It is therefore difficult to assess the effectiveness of these measures. However, some information is available on the use of leave by informal carers. Estimates, based on different surveys⁵, have suggested very low-take up of existing leave provisions, at only 7% of interviewees. A majority of carers (between 50% and 80%) were unfamiliar with the leave provisions (Sirven, Naiditch and Fontaine, 2015). In fact, working carers tend to use standard leave (sick

leave) or even annual leave, rather than specific carers' leave, to combine work and care. In the national HSA survey, it emerged that 24% of working carers⁶ of old people (over 60) had already taken a period of leave to carry out their caring role (Soullier 2012). The cash benefits designed to remunerate carers apply to a large number of people – cared for and carers - depending on the allowance. In France in 2015 there were 738,200 beneficiaries of the Personal Allowance for Autonomy (APA) at home (CNSA 2016). But as far as we know, no rigorous estimate has been published in France of the impact of these cash benefits on carers.

Concerning the respite or information measures, there are no consistent impact studies of the effectiveness of the schemes implemented. Yet some analyses have underlined the role of the recent respite and support platforms (see the accompanying document to this report) to support both carers and cared for people. Giving carers comprehensive information concerning the different solutions for the care of their old relative, these platforms also provide for respite and support them in the socialization process of becoming a carer (Le Bihan et al. 2014; Le Bihan and Mallon (dir.), 2013).

As a pillar of the elderly care policy, the National Solidarity Fund for Autonomy (CNSA) has carried out a mission to look into the issue of a policy for carers (Eneis Conseil and CNSA, 2015). In this perspective, the report questions the impact of the existing schemes on the carers. Confirming the analysis of the CGS Mines Paris Tech Report of 2012 (Sand et al., 2012), the report underlines the lack of impact studies on the different policy measures. Based on three criteria – the wellbeing of carers, the health situation of the cared for person and the moment the elderly people move into residential care – the existing epidemiological studies are considered insufficient as they do not

⁵ Two online surveys carried out between 2013 and 2015, initiated by associations for disabled people (APF) and a mutual insurance plan (MACIF).

⁶ This covers only carers involved in everyday tasks (domestic or personal) and does not include carers whose support is only financial, administrative or moral.

Box 4. Evaluation of the efficiency and impact of measures to support carers co-funded by CNSA (Eneis, 2015)

The analysis proposed in the report concerns five issues and is based on a literature review and where possible a case study:

- Training: assessment of four training projects and analysis of their impact for the non-profit organizations involved, for the three regional health agencies and departmental councils concerned and for the carers;
- Information: assessment of two local initiatives;
- Social and moral support: different local initiatives led in six départements;
- Health prevention: no case study. Results of the survey of the National Association of Carers: 'Carers' health: let's talk about it';
- Respite: assessment of the measures developed in three départements.

As the method is based on case studies, it is difficult to draw conclusions concerning the effectiveness of the different measures. Yet the report underlines the necessity to improve the organization of the offer of services in terms of coherence and complementarity.

It highlights four main areas for improvement:

- identification of carers who are suffering from exhaustion;
- assessment of the living situation and adaptations of the carers and cared for;
- development of the national policy for carers;
- clarification of the offer of services and services in a territory through the Funders' Conference for the prevention of elderly people's loss of autonomy.

take into account the diversity of the existing factors – such as the resort to other schemes than the one assessed and the social environment of the person – and as the carers' needs vary as the situation develops. The CNSA report also gives the results of the evaluation carried out to assess the impact of the measures co-funded by the agency (see above). The evaluation method is based on interviews with 21 actors to assess the efficiency and the impact of a sample of selected schemes to support carers (see Box 4).

An analysis of policy measures in France leads us to make some recommendations:

- Expand the range of leave options available for family carers. Qualitative studies (Le Bihan et al. 2013) show that carers need flexibility to deal with unexpected events, plan appointments with the doctor or home care services, or carry out administrative tasks. This calls for creating short-term paid leave solutions.
- Continue improving information for carers on existing measures, as well as for professionals in contact with families (especially general practitioners and specialist doctors).
- Develop respite and support platforms which give support to the couple 'carer-cared for' and propose solutions adapted to the situation.
- Increase care delivered by professional carers for people with high needs. Carers of this group of people report a higher rate of withdrawal from the labour market.

Theme 4: What innovative care models/technologies could improve outcomes for people with LTC needs?

Innovative care models including personalization of care have developed in France since the 1990s (cash for care, vouchers and case management) as well as innovative technologies. Different types of services are considered here, with a focus on *telealarm*, *teleassistance* and other

gerontechnologies such as building and safety technologies (*domotique*) and robotics. Other themes – such as housing accommodation and technical aids, often implying the intervention of an occupational therapist – will also be briefly referred to in the sections below. It must be acknowledged

that all these technologies have different rationales according to their final purpose⁷ and to the type of actors involved.⁸

Policy Context

The development of personalization in France

Personalization of care has been introduced in France as a main solution to meet the needs of elderly people and to respond to financial pressures. It has developed since the 1990s through different schemes, some of which have already been described in this report:

- The French cash for care scheme introduced in 1997 as the ‘Specific allowance for dependency’ which was reformed in 2002 and became the current APA – Allocation personnalisée d’autonomie – Personal allowance for autonomy. (See box 2 for a description of the APA.) Though financial support to elderly people is a main dimension of the cash for care allowance, the objective was also to enable a personalized care arrangement, adapted to the needs of the older person and his/her family. As explained in the introduction of this report, the allowance is delivered to older people according to their level of dependency. The latter is assessed on a national scale (AGGIR grid), which defines six levels of dependency (from the highest, 1, to the lowest, 6). If the older person is assessed at level 1 to 4, a care plan is discussed between the multidisciplinary team of the département (health and social professionals) and the care users (the older person and her/his family) in order to define the number of hours of home help needed and sometimes the physical reorganization of the home. The care plan is signed by the care recipient. The benefit is controlled and can only

be used to finance the defined care plan. Finally, one of the social workers from the multidisciplinary team of the département is in charge of the follow up of the situation in order to adjust it to changes in the situation of the care recipient.

- To facilitate the development of personalized home care arrangements, a ‘service employment voucher’ (*chèque emploi service*) was created in 1994 – simplifying the procedure for paying people working within the home. The voucher was modified in 2005 and became the ‘universal services voucher’ (*chèque emploi service universel*) which introduced further simplifications of administrative procedures for employers.

The development of case management through specific procedures and new professionals (case managers) is also part of the French personalization policy in the elderly care sector. It has been introduced at the end of the 1990s with the creation of the benefit for elderly people in need of care (the specific dependency allowance, which became the APA in 2002) and has been a main dimension of the LTC policy since the 2008 Alzheimer Plan and more recently of the health care policy. See theme 5 in this report for details.

The development of new technologies in France

Telealarm and *teleassistance* services were introduced in France in the 1970s and developed progressively in the 1980s, initially with a focus on disabled people. The dynamic was enlarged to elderly people in the 1990s (Gucher et al. 2014), following two different paths (Ennuyer 2014, p. 144): in a bottom-up perspective, based on local initiatives privileging a social inclusion logic, in which the role of local territorial communities, home care services and sociability networks around the elderly person played a major role; and a top-down perspective, based on national initiatives in which the role of private entrepreneurs and institutional actors (such as the old age insurance funds) were determinant. The top-down approach is also more technical and follows a more commercial logic.

⁷ Three different functions can be distinguished: surveillance and observation, remote assistance, and communication (Le Borgne-Uguen and Pennec 2016). See also Gucher et al. 2014 for a typology, p. 182.

⁸ These can be local political actors, technology developers, elderly people and their families, as well as a range of other health, social and medico-social professionals intervening with the elderly person (Pennec and Gutierrez Ruiz 2014).

These initiatives have been implemented across French territory in a very haphazard and unequal manner. A public note from the Centre for strategic analysis (CAS) acknowledged in 2009 that, compared to other European countries, such as the United Kingdom, Germany or Denmark, there has been a significant delay in France in the development of gerontechnology (CAS 2009). In 2008, only 4% of elderly people (60+) had a telealarm device (a total of 556,000 people), compared to 3.3% in 1999 (Bernardier 2012, p. 5). These are predominantly used by the most dependent elderly, representing a total of 43% of the APA beneficiaries: 18% for levels 1 and 2, and 25% for levels 3 and 4.⁹ Elderly people living alone also benefit more frequently (11%) from a telealarm than others (1%). According to the same sources, up to 24% of the APA recipients (levels 1, 2, 3 and 4) report needing a *telealarm* against 3% for all elderly people 60+.

As analysed in a number of reports¹⁰, the reasons for this delay are various in nature: the weakness and lack of uniformity of this industrial sector composed of a disparate mix of industrial subsectors (mechanics, electronics, building and safety technology, pharmaceuticals, etc.); the cost¹¹ of gerontechnology for users given the low level of public subsidies; the lack of interest due to a generational gap; or professional resistance to introducing such technologies due to concerns related to the lack of evidence for their efficiency or to their potential to replace interventions requiring human commitment (CAS 2009, see also Gucher et al. 2014). Another explanatory factor is the substantial delays necessary to their

⁹ See Box 2 about the APA allowance and the different levels of dependency in the introduction.

¹⁰ Riaille 2007, Picard 2008, Boulmier 2010, CAS 2009, ALCIMED 2007, Franco 2010, cited in Pennec 2012, p. 120.

¹¹ The users' fees for teleassistance and telealarm services are from €15 to €50 per month, according to their earnings. Local authorities make a large contribution to financing as 45% of municipalities between 5000 and 200,000 inhabitants propose such services with 530,000 elderly people in 2013 using them (Ennuyer 2014).

implementation, the lack of information concerning their very existence and use or their fragmented financing (IGAS 2014, Pennec 2012, p. 120).

However, the end of the 2000s represented a real turning point in the development of gerontechnology in France. In 2007, three different reports putting the accent on the potential of new technologies to ameliorate both professionals' practices and elderly people's everyday life – the reports Rialle¹², ALCIMED¹³ and Picard and Souzy¹⁴ – contributed to place the issue of new technologies on the public agenda. The same year, the French society of technologies for autonomy and gerontotechnologies (SFTAG)¹⁵ was created, followed two years later by that of the National centre of reference, health at home and autonomy (CNR Santé) that became France Silver Eco in December 2014. Its aim is to facilitate the development and the use of information and communication technologies (ICT) in health care and for dependent people living at home. In 2009, two other public reports – one for the Minister of health and sports, Roselyne Bachelot (Lasbordes 2009) and an international study for the Caisse des dépôts (2009) – were released.

2010 is another important year. It was marked by the creation of the Association of innovative solutions for autonomy and gerontechnologies (ASIPAG)¹⁶ by a number of industrial entrepreneurs¹⁷ and the launch of the mission 'Live in your own home' by the secretary of state for elderly people, Nora Berra. Both initiatives explicitly target elderly people in

¹² Submitted to the Minister of health and of solidarities (Philippe Bas) and prepared at his formal request.

¹³ A prospective study performed by the company ALCIMED on health technologies and autonomy and requested by the National research agency and the CNSA (national solidarity fund for autonomy).

¹⁴ General council for information technologies.

¹⁵ Société française des technologies pour l'autonomie et gérontotechnologies.

¹⁶ Association Solutions Innovantes pour l'autonomie et gérontotechnologies.

¹⁷ In 2011, the ASIPAG produces a label related to the use of technologies for the economy.

need of care and put the accent on information technologies and services. Another public report, in 2013, recommended the professionalization of the sector and a simpler financing for users' fees (IGAS 2014). Finally, the Broussy report – which was also published in 2013 and prefigured the Act on adapting society to an ageing population of December 2015 – stresses the necessity to develop a specific industrial sector for technologies and services in the field of personal autonomy (Broussy 2013). The same year, a report released by the General Commissariat for Planning and Forecasts¹⁸ defined the scope of such an economic and industrial sector and acknowledged that its development would strongly rely on those elderly with the highest purchasing power (CGSP 2013). A month after the publication of the Broussy report, a new industrial field termed the 'silver economy' was promoted, represented by the deputy minister for elderly people at a time as a promising area and a new market opportunity in the elderly care field.¹⁹ It established a 'silver economy contract' to orient actions in the sector in future years. In September 2015, its national committee created five thematic groups to formulate proposals for the removal of obstacles to the participation of private actors in the development of this area.²⁰

All these reports recalled the analysis for the causes for France's delay in the development of gerontechnologies exposed above, and put the accent on the capacity of the latter to respond to the needs and wishes of frail elderly people and their families to stay as long as possible in their homes, as well as to those of the professionals who support them. But, above all, they underline the economic opportunity in the ageing of the

population as a source of growth. The Broussy report further acknowledged that the development of new technologies cannot be left to the private sector alone and recommended guiding the industry by creating a dedicated national agency (Broussy, 2013, pp. 24, 115, 122, 132).²¹ It also highlighted the need to develop appropriate education of elderly people in using these technologies²² (ibid, p. 136). Finally, it underlined the need to develop appropriate information and communication policies to accompany the development of the sector.

Recent developments

The Act on adapting society to an ageing population from December 2015 encompasses several of these recommendations. It supports the development of the 'silver economy' industrial sector by laying out France's ambition to become the first world leader in the silver economy. According to the text of the law, the definition of the 'silver economy' sector encompasses a very broad perspective from the most sophisticated building and safety technologies (*domotique*) and robotics to the simplest technical aids and *teleassistance* services for the housing, mobility or 'senior' tourism sectors. In this perspective, new technologies are praised again for their likely impact on growth, industrial development and employment. The national governance of the 'silver economy' industrial sector launched in 2013 is maintained, and reinforced in the territories with the creation of the 'silver regions' – regional committees under the responsibility of the regional councils – and regional coordination bodies to guide the development of this industrial sector in each region. The scope of the CNSA has been extended to cover technical aids.

The overall strategy of the Act on adapting society to an ageing population is to contribute to the development of the silver economy by making technical aids and other gerontechnologies

¹⁸ Commissariat général à la stratégie et à la prospective, CGSP.

¹⁹ It is piloted at the national level by a strategic committee composed of 40 professional federations and public actors – particularly the regions – in charge of developing this branch on their territories.

²⁰ The committee acknowledged that half of the measures formulated in the contract from 2013 had been implemented, but mostly by public actors, www.entreprises.gouv.fr/politique-et-enjeux/la-silver-economy, last accessed on May 10, 2017.

²¹ This proposal was not included in the Act on adapting society to an ageing population from December 2015.

²² See also Collos (2013); Brugière (2011) or Caradec (2001).

financially more accessible to their users, especially to those with the lowest incomes. It targets the creation of a specific means-tested public benefit for elderly people with the lowest incomes to provide a number of interventions aimed at preventing loss of autonomy, such as technical aids, teleassistance services, housing adaptations, and building and safety technologies. From the same perspective, it considers the acceleration of personal housing accommodation by increasing the number of people eligible to financial benefits for accommodation work from the elderly insurance fund (CNAV), which would include gerontechnologies. The law also creates a system of ‘microcredits’²³ for the adaptation of homes of those elderly not eligible for regular bank loans, and enlarges the list of work eligible to tax credits for those who do have the means.²⁴ Finally, the 2015 Act on Adapting society to an Aging population has increased the maximum amounts allocated to each level of dependency, to assure better coverage of older people’s needs. Confirming the importance of personalization of care (the importance of the older person’s own choices, priority given to home-based care, development of a negotiated adapted care plan, follow up of the situation of the older person) – this revalorisation of the APA also contributes directly to the objective of development of the silver economy sector. By decreasing users’ direct contribution to the cost of the care plan, it potentially increases their ability to invest in gerontechnologies. It also extends the type of services financed by the APA to those related to the adaptation of personal housing or technical aids. When these cannot be covered by the APA, the care plan must contain indications about other existing sources of financing, such as the financiers’ conference to prevent elderly people’s loss of autonomy created by the same law or the national housing agency (ANAH).²⁵

Effectiveness of the policy measures

The introduction of the APA in 2002, reforming the existing benefit, was a success. The number of recipients has increased from 143,000 in 2001 (previous allowance) to 596,914 in 2002 (following the APA reform) to 1,223,290 in 2012, representing 8% of people aged 60 years and more (only 4.7% in 2002). It has currently stabilized at around 1,250,000 recipients. Yet the personalization process has met some significant difficulties:

Financial difficulties: In 2003 the cost was €1.2 billion more than anticipated. To avoid further increase of the costs, an adjustment to the financial eligibility criteria was introduced in March 2003, so users with monthly income below €623 did not have to contribute to the payment of their care (€949 prior to March 2003).

The 2015 Act adapting society to an Aging population has increased the maximum amounts allocated to each level of dependency, to assure better coverage of elderly people’s needs. Although a new tax has been created to finance this expenditure (the CASA, a tax on pension paid to the CNSA – National Solidarity Fund for Autonomy; see box 1), the financing will face pressure as numbers receiving the allowance increase with the generation of baby boomers growing older. The budgets of the départements are already under strain to pay the allowance and this will only increase.

Management difficulties: Social workers from the multidisciplinary team of the département are in charge of more than 200 cases, and therefore close follow up is impossible. The new professionals (case managers) who have been recruited in the MAIAs (see theme 5) and who deal with the so-called ‘complex cases’ are in charge of only 40 cases. While this is real progress in terms of quality of the monitoring, it has created serious tension between the professionals from the départements and the new case managers.

A number of criticisms have also been made concerning the development of gerontechnologies

²³ €40,000,000 over two years, press release 2014.

²⁴ €4,000,000 over two years, press release 2014.

²⁵ Decree no. 2016-210, 26 February 2016.

since the end of the 2000s. The first is economic in nature. As it is the case for a number of other measures created by the law, investment from the public sector remains very low. For growth to occur, there is still a need for public funding as most elderly people may not be able to afford new technologies. In that perspective, development of new technologies in health and social care is seen by the French health ministry as a strategy including public private partnership (Moret 2016). Others put the emphasis on the necessity to better delimit the potential market represented by new technologies in the elderly care field and to devise an adequate economic model for its development (Gucher et al. 2014).

A second level of criticisms – closely related to the first one – is the difficulty of promoting the use of expensive technology, as mentioned by Broussy (2013). Given the low propensity of health care professionals to provide information on gerontechnologies highlighted in previous reports (see above), Broussy proposed to build on the UK experience, where medical doctors can prescribe them (2013, p. 136). However, without an adequate payment from health insurance, the incentive would not meet the expected effect. In any case, this does not provide a comprehensive solution to the difficulty of promoting the use of such equipment to a generation that have difficulties to accept new technologies.

Other criticisms concern different aspects of the use of such gerontechnologies: the effects they produce on the elderly people in contact with them, on the one hand, and some ethical considerations, on the other.

New technologies for elderly patients are seen as a game changer by some advocates as they should

help the elderly to be able to stay at home safely and allow them to participate fully in life. However, where the elderly may not adapt or even accept the presence of a new technology, then the use of these seems difficult (Barnard et al., 2013).

A number of researchers have provided evidence on the low acceptance levels of elderly people for new technologies and the stigmatisation effect they produce, thus accentuating their isolation and feeling of strangeness to their immediate environment (Raulet-Croset et al. 2010, Collos 2013, Brugière 2011, Caradec 2001). Other studies acknowledge that the use of such devices – such as telealarms – reveals a more profound need of social inclusion and social contacts beyond the emergency care on which their introduction initially focused (Roulet-Croset et al 2010; Pennec and Gutierrez Ruiz 2014).²⁶ Given those results, it seems necessary to develop an overall approach responding to both effects that are at the same time contradictory and complementary (Ennuyer 2014).

Finally, a number of reports and academic work explore the ethical issues surrounding the development of gerontechnologies, especially when the latter is based on the participation of private providers (Ennuyer 2014) or on the development of geo-tracking devices (CNBD 2013, CNIL 2013). These issues concern both professional and relatives' practices, especially for elderly people with cognitive disabilities, but are scarcely touched on (a single line) in the recent Act on adapting society to an ageing population. As highlighted by Gucher et al. (2014), the relevance of the use of new technologies in the elderly care field is not a subject of debate on the political agenda.

²⁶ According to Ennuyer (2014), only 5% of the calls are related to an emergency such as a fall or a feeling of discomfort.

Theme 5: What strategies can maximize coordination in care provision?

Context: development of integrated elderly care in France

Coordination in the elderly sector is at once a longstanding preoccupation of the state (Henrard and Vedel 2003; Amyot 2006) and a response to the highly fragmented organization and funding of health, social and what are referred to as ‘medico-social’²⁷ interventions (Henrard 2002; Bloch and Hénaut 2014) in the elderly care field.

A number of dedicated measures, such as the ‘gerontological action coordinators’ for the social sector, and ‘gerontological health networks’ for the health sector introduced in the 1980s, have addressed the need for coordination with the objective of creating links between existing organizations and professionals. During the 1990s, multidisciplinary care teams were introduced in the départements as part of a national reform creating the cash for care allowance (see introduction). These represented the first form of case management procedure for elderly people (Frinault 2009) involving professionals from both the health and the social sectors. In the same period, ‘local information and coordination centres’ (Centres Locaux d’Information et de Coordinatin – CLIC) were developed, to help care users find their way through the maze of mechanisms by introducing a one-stop shop for social care services (Frossard *et al.* 2004). In parallel, within the health sector, coordination initiatives were developed – such as gerontological networks, geriatric health networks, mobile geriatric teams, hospitalization at home or hospital geriatric pathways – with a more and more explicit objective to limit the use of costly hospital care for the elderly patients (Bloch and Hénaut 2014). However, a major characteristic of all these measures is that their creation and functioning reproduced, and even reinforced, previous fragmentations, leading some analysts to talk about

‘impossible coordination’ in the French context (Ennuyer 2014).

Recent developments

During the current decade the issue of coordination has continued to be high on the political agenda as shown by the trend to create new coordination schemes, embracing all three care sectors – social, medico-social and health. Three different schemes have been developed – the PTA, the MAIA, and PAERPA schemes – having in common the creation of specific functions or professionals to support the social, medico-social and health professionals in their coordination tasks (see Boxes 5, 6 and 7 for brief summaries and the policy templates for more details).

Box 5: The PTA scheme

The PTA scheme – or territorial support platforms for coordination (Plateformes territoriales d’appui) – was created by article 74 of the law on modernizing the health system from January 2016, as part of series of measures centred on primary care and on the necessity to structure the health pathways perspective.¹

The platforms’ aim is to offer support to health, social and medico-social professionals for the coordination of complex health pathways in order to prevent avoidable hospitalizations and discontinuities in the care delivered.

The PTAs are not population-based, as are the MAIA and the PAERPA, and propose a more general approach to the complexity of the patients’ situations, independently from their age. The territorial coverage of the PTA scheme is still very low as it is still under development.

¹ Some of these measures consist of the creation of primary care teams around a general practitioner and other frontline professionals having a common health project (Art. 64) and of professional health territorial communities, allowing coordination of the various primary care teams and linking other health specialists and medico-social professionals (Art. 65).

²⁷ A French specific sector alongside the health and social sectors, whereas the English only distinguishes “health care” and “social care” sectors.

Box 6: The MAIA scheme

Created by the third national plan on Alzheimer's disease (2008-2012), the aim of the MAIA scheme is to integrate health and social care in the elderly field. The acronym initially meant 'Maisons pour l'autonomie et l'intégration des malades d'Alzheimer' (Centres for the autonomy and integration of Alzheimer's patients). As part from the Alzheimer's plan, it initially targeted elderly people 60+ suffering from Alzheimer's or related diseases. The Act on adapting society to an ageing population modified the acronym to 'Méthode d'action pour l'intégration des services d'aide et de soins dans le champ de l'autonomie' (Method of action for the integration of health and social services in the field of autonomy) emphasizing its project dimension¹ and extending it to all elderly people 60+ with complex health and social care needs.²

The scheme is based on three integration mechanisms: a consultation process between institutional and professional actors called respectively 'table stratégique' (strategic meeting) and 'table tactique' (tactical meeting), an 'integrated entry point' (guichet intégré) and intensive case management for complex cases (gestionnaire de cas). It also includes three tools: a multidimensional analysis and evaluation, an individualized service plan and a shared information system. Its functioning is ensured by a MAIA pilot recruited to foster integration dynamics across the scheme's territory, alongside between two and five case managers in charge of up to 40 complex cases each.

The MAIA scheme was first tested in 17 localities as a pilot (2009-2011), and then extended to the whole territory. It is currently being extended, with 352 schemes operating by December 2016. According to a national evaluation report by the CNSA, 85% of the country is covered by the scheme in June 2016 (CNSA 2017; see Figure 1).

Figure 1. National coverage of the MAIA scheme on 1 February 2017



Source: CNSA, 2017: www.cnsa.fr/parcours-de-vie/maia

¹ To which the term 'method' refers. The term 'centre' used in the first acronym led to confusion as it suggested the creation of a new a physical space (de Stampa and Somme 2011).

² In practice, considering the target group, frontline professionals have made a larger use of it since 2011 (Cour des comptes 2016).

Box 7: The PAERPA scheme

The PAERPA scheme – ‘Personnes âgées en risque de perte d’autonomie’ (Elderly people at risk of loss of autonomy) – is a specific health pathway combining a range of tools in a prevention perspective targeting elderly people aged 75+. Created by the Social security financing law for 2013, it has been implemented as a pilot since 2014 in nine territories and was extended to each French region in 2016.

The PAERPA scheme has five interdependent objectives corresponding to five different steps in the elderly person’s health pathway: (1) preventing elderly people’s loss of autonomy by identifying at an early stage risk factors potentially leading to hospitalization and/or institutionalization; (2) ameliorating the coordination of health and social care in order to formulate an adequate response at the lowest cost; (3) securing hospital discharges; (4) avoiding unplanned hospitalizations and 5) better use of medicines. The scheme leans on a coordination process between frontline professionals called ‘close clinical coordination’ (‘coordination clinique de proximité’ – CCP) and provides support to frontline professionals – especially general practitioners – in their coordination functions through the so called ‘dedicated territorial coordination’ (‘coordination territoriale d’appui’ – CTA). The scheme provides different tools to develop care coordination such as personalized joint health care plans or information sharing: mainly standardized information sheets and a secure messaging system common to all three sectors, developed at the national level by competent institutions.

The national coverage of the PAERPA scheme is still very low (see Figure 2).

Figure 2: National coverage of the PAERPA scheme after its extension in 2016



Source: Ministry of Social Affairs and Health

Effectiveness of the policy measures

All three dedicated coordination schemes created since the beginning of the 2010s underline the necessity to ameliorate the coordination – and in the case of the MAIA scheme, the integration – of the health, social and medico-social sectors, organizations and professional interventions. The types of mechanisms and governance bodies they lean on are also very similar. Both the MAIA and the PAERPA schemes develop governance bodies at the decision-making or institutional (the so-called strategic) and organizational (tactical) levels, and put

the accent on the necessity to formalize an integrated entry point, common tools, pluriprofessional work and information sharing, on the one hand, and to support professionals in the coordination tasks related to complex situations, on the other.

As far as national coverage is concerned, the MAIA scheme remains the most widely implemented, even if its coverage is not perfect. The territories covered by the pilot and first wave schemes are smaller,

often corresponding to those of pre-existing forms of coordination. This raises the question of the way bordering territories, where no coordination dynamics exist, would be covered (Cour des comptes 2016). The coverage of the PAERPA scheme is still very partial, but its extension in 2016 to each region before the end of the pilot evaluation, leaves no doubt on the final decision on its generalization.

Despite their similarity, the three schemes differ in the population they target and their focus on prevention, care or cure. The MAIA and PAERPA schemes are specific to the elderly care sector (targeting respectively elderly people aged 60+ and 75+), whereas PTAs propose a more general (and not age-related) approach. MAIA and PTA schemes are dedicated to complex situations, defined as situations where health problems are coupled with social (family, housing), legal, and other problems, whereas PAERPAs are based on interventions aiming at preventing the risk of loss of autonomy. Nevertheless, as highlighted in a recent report, in practice, the majority of personal health plans drawn up by professionals concern elderly people with severe health problems and already in loss of autonomy (Gand et al. 2017, p. 38).

The schemes also differ in the degree to which they encompass the three intervention sectors concerned. The MAIA scheme's objective of integration of all three sectors is the strongest, even if it is formulated from a more social care perspective (IGAS 2014). This is due to different factors, such as the absence of medical doctors within the MAIA team and also partly to the fact that they are carried in a majority of cases by the départements²⁸ (35%) or social structures such as CLIC (28%) or MDPH (1%) (CNSA 2017). The PAERPA scheme goes further as far as financial integration and shared tools are concerned as different national agencies contribute to its realisation, even if they need to be reinforced (Gand et al. 2017). Finally, the PAERPA scheme and

particularly the PTA scheme are much more health care oriented, as they put the accent on primary care as a pivot of the care system, and lean on the way primary care and medico-social interventions are coordinated with hospital services before and after a hospital stay, as a means to avoid unplanned hospitalizations and emergency stays, hospital readmissions, and institutionalizations. The objective of cost-effectiveness of the latter schemes is also defined in a much more explicit way.

From a public policy perspective, the analysis of those recent developments shows that despite their initial objective of improving coordination between the health, social and medico-social interventions and facilities, the creation of three dedicated coordination schemes has also contributed to the complexity of elderly care professional and organizational landscape. Each of the evaluation reports of the MAIA and the PAERPA schemes – CNSA (2017), ANAP (2016) and DREES (Gand et al. 2017) – puts the accent on the complementarity with pre-existing and recently created coordination schemes and underline the necessity not to superpose their interventions. They also analyse – for each one of the schemes and independently from one another – their first positive impact in terms of continuity of the health and social care interventions.

And yet, when analysed together, the different dedicated coordination schemes described in this report are clearly overlapping. As underlined in two more comprehensive reports – Cour des comptes (2016), IGAS (2014) and DREES (Gand et al. 2017) – there is a lack of coherence between them in terms of decision-making, institutional responsibilities, financing and implementation. The different schemes fall under the responsibility of different institutions – the CNSA and the Department of Social Cohesion for the MAIA scheme, the Department of Social Security for the PAERPA and the Department of Health Organization and Delivery for the PTA – which determines their financing, implementation and functioning in silos. The necessity of better institutional, decision-making

²⁸ French equivalent of local authorities.

and financial integration at the national level has also been underlined. At the organizational level, their successive creation results in lack of clarity on the way they interact and function for local institutional and professional actors, and also for users. The variety of sources of funding and of procedures, as well as the lack of flexibility in their use, create practical difficulties for health and social care organizations and professionals in adhering to these coordination-related sources of financing and payments.

Further, the different types of tensions resulting from this overlapping – between the national, regional and local administrations concerned and the health and social care organizations they are responsible for, as well as between the different professionals involved – this continuous creation of successive schemes with similar objectives is also proving to be

very costly for the local authorities, social security and the state. As highlighted in the report from the IGAS on dedicated territorial support for coordination (2014), the overall cost of a range of schemes with common coordination objectives – such as the health networks, the CLICs, the MAIAs, the PAERPA, the coordination mission of the health centres, or the different coordination payments to the health professionals or groups of professionals – represents a total of €898 million per year. This amount is an estimate and is likely to be higher, given the fact that costs related to all the schemes concerned is difficult to evaluate (and has never been evaluated) due to the lack of centralized information on their financing. Furthermore, this amount does not include the recent financing of the PTAs. This makes the evaluation of their functioning and impact, both in terms of continuity of care and cost-effectiveness, even more difficult.

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