

July 2002

**QUESTIONNAIRE ON HEALTH AND
LONG-TERM CARE FOR THE
ELDERLY**

France's Contribution

The 1999 census showed that more than one in five residents of metropolitan France was aged over 60 and one in four was aged under 20. When compared with data from earlier censuses, these figures show that the population of metropolitan France is ageing. The over-sixties now account for 21.3% of the population, as opposed to 19.9% in 1990 and 18% in 1970. On the other hand, the proportion of under-twenties shrank from 26.5% in 1990 to 24.6%. The proportion of over-sixties in the population of France's overseas territories is smaller at 12.1%.

POPULATION CHANGES 1990/1999

	1990 Census	1999 Census	1999/1990 %
Metropolitan population	56,625,000	58,521,000	+ 3.3
Population aged under 20	14,987,000 26.5%	14,381,000 24.6%	- 4
Population aged 20/39	17,139,000 30.3%	16,468,000 28.1%	- 3.9
Population aged 40/59	13,200,000 23.3%	15,193,000 26%	+ 15
Population aged over 60	11,299,000 19.9%	12,479,000 21.3%	+ 10.4
Of which aged over 75	4,038,000 7.1%	4,505,000 7.7%	+ 11.6

Source: INSEE

All the projections show an inevitable increase in the proportion of the elderly in the metropolitan population as a whole. Unless there is a totally unforeseen change in the birth and death rates and if migratory patterns remain unchanged, the increase in the proportion of the elderly is inevitable, since all of the generations that will reach the age of 60 before the year 2050 have already been born.

As "baby boomers" age, there will be a steady increase in the proportion of over-sixties to 27% of the population by 2020 or 17 million people, which is 1.4 times more than in 2000. Meanwhile, the over-seventy-fives born in the first years of the baby boom, meaning 1944 and 1945, will account for 9.5% of the population and the over-eighty-fives will account for 3%. By 2040, the number of people aged over 60 should increase by nearly 10 million compared to the 1999 census figures. The same forecasts show that the number of labour force participants and the number of under-twenties should decrease by one million each. In 2050, one-third of the population should be aged over 60, 15% should be aged over 75 and 7% over 85. However, increasing age does not inevitably mean increasing disability. Quite the contrary, the most likely scenario for the final years of people's lives is now one of "compressed morbidity." In the nineteen-eighties, the increase in disability-free life expectancy was greater than the increase life expectancy per se. More recent research has shown that this trend persisted into the nineteen-nineties.

- ACCESS -

1.1 ACCESS TO HEALTHCARE

1.1.1 Mechanisms for guaranteeing access

The French health insurance system is based on universality and solidarity. All residents are covered through socialised financing regardless of their age, income or their health condition. Full coverage is provided for those with the lowest income (8% of the population).

- **Dual healthcare provision system and free access to care for recipients**

Healthcare is available from both public-sector and private-sector providers. In 1998, 75% of general practitioners and 68% of specialists were in private practice, 65% of hospital beds were in the public sector and one-third of the hospital beds in the private sector were in not-for-profit institutions. Private practice healthcare professionals are paid on a fee-for-service basis according to a scale of charges set by agreements negotiated between the health insurance system and professional bodies. A quota system restricts the number of places in healthcare education. Professionals are free to locate their practices where they like. This is also true for retail pharmacies, which are privately owned, but authorisation is required to open shops. The prices of drugs reimbursed by the insurance system are negotiated between the Economic Committee for Health Products and pharmaceutical companies. An overall yearly budget is set for each hospital in the public and not-for-profit private sectors. For-profit hospitals are paid on a fee-for-service basis.

Patients have a free choice of providers and healthcare institutions and they have direct and unrestricted access to care, including care provided by paramedical professionals, general practitioners and specialists, hospital outpatient clinics and hospital casualty rooms. Patients pay for the care they receive. This means they advance the money for fees and are then reimbursed by the health insurance system. However, in some cases, the system pays the fees covered by the insurance directly to the providers. This is the “third-party payer” principle and it applies in virtually all cases of hospitalisation in public-sector or similar institutions.

- **A Bismark-model insurance system that now provides universal coverage**

The French healthcare system was originally based on the Bismark model. It started out as a set of occupational health insurance schemes but was gradually extended to cover the entire resident population.

The population is covered primarily on the basis of occupation, and secondarily on the basis of place of residence. Affiliation with a healthcare scheme is compulsory for all workers and former workers (invalids, pensioners, unemployed, etc.) The main health insurance schemes are the General Scheme for Wage-Earners, which covers some 80% of the population, the scheme for farm labourers and farmers and the scheme for self-employed non-farm workers, which cover 9% and 6% of the population respectively. There are other, smaller, schemes for specific occupations (mining, railways, seamen, etc.) Since 2000, the

remaining 2% of the population that was not covered by an existing occupational scheme has been required to join the General Scheme under the terms of the Universal Health Coverage Act.

Subject to international commitments, any person residing lawfully in France or its overseas *Départements* for more than three months is now covered by one of the compulsory health insurance schemes for in-kind benefits by virtue of their occupation or place of residence.

- **Health insurance covers most healthcare costs**

In 2000, the health insurance system covered 75.5% of current expenditure on healthcare and therapeutic appliances. The rest was covered by private insurers offering supplementary coverage through individual or company policies (12.3%), by central government and local authorities (1.1%) and by the patients themselves (11.1%).

The various schemes provide very similar coverage. For example, the General Scheme covers all general practitioner and specialist medical fees, care and prostheses, pharmaceuticals, therapeutic appliances for individual use, laboratory examinations, hospitalisation and treatment expenses in healthcare institutions and, in certain cases, transport expenses.

The health insurance schemes require the beneficiaries to provide co-financing for a portion of the expenses. In-kind benefits are reimbursed up to the scale of charges set by the insurance schemes. The beneficiary is required to co-finance a percentage of the charge known as "*ticket modérateur*" (deterrent fee). The deterrent fee was originally introduced to encourage responsible behaviour on the part of patients and to curb expenditure. It requires patients to co-finance 30% to 40% of the fees charged by doctors and paramedical care providers, 35% to 45% of prescription charges and 40% of laboratory charges. Patients co-finance 0% to 20% of hospitalisation charges and 35% of therapeutic appliance costs. However, there are co-financing exemptions and reduced rates for certain treatments and for certain categories of pensioners and for patients suffering from long-term illnesses. Co-financing charges for people on low incomes are covered by a supplementary insurance scheme under the terms of the Universal Health Coverage Act.

Some doctors, specialists primarily, and some dentists providing prostheses, are authorised to charge more than the set scale of charges. Since 1991, this authorisation has been restricted to certain hospital doctors who decide to go into private practice. The prices for some therapeutic appliances, such as eyeglasses, dental prostheses and hearing aids, are not controlled and can sometimes be much higher than the set scale of charges. The patients must meet the excess costs. However, the producers, distributors and providers concerned must comply with a set of minimum charges for beneficiaries of the Universal Health Coverage Act, who are then fully reimbursed.

A very large proportion of the population has supplementary insurance from mutual or private insurers to cover some or all of the cost of medical care and therapeutic appliances that is not covered by compulsory health insurance schemes. Supplementary insurance may cover the co-financing paid by patients under the fixed scale of charges, charges that exceed the fixed scale and, more specifically, the difference between the fixed scale and the charges paid for certain therapeutic appliances, such as eyeglasses, dental prostheses and hearing aids.

This supplementary insurance is voluntary and it is available through company health plans or individual policies. These insurance schemes reimburse patients for some or all of their co-financing expenditure, or else they make direct payments to providers and healthcare institutions in accordance with the “third-party payer” principle.

The Universal Health Coverage Act also provides low-income patients with free supplementary coverage provided through direct payments to providers. Some 8% of the population living on an annual income of less than 6,744 euros (for a single person, adjusted according to the type of household) has such supplementary coverage provided by their health insurance scheme or another insurer.

- **Healthcare access provisions aimed specifically at the elderly**

The health insurance schemes’ main provisions to ensure access to healthcare specifically for the elderly include:

- facilitating house calls by healthcare professionals,
- co-financing exemptions for treatment of a list of long-term illnesses (55% of the beneficiaries of such exemptions are aged over 60),
- special coverage of healthcare provided by visiting nurses and, healthcare provided to persons living in institutions (retirement homes, long-term care facilities, etc.)

1.1.2 Assessment

There are no waiting list indicators for any type of healthcare. The quantity of healthcare provision and the principle of free access ensure satisfactory access to healthcare for the population as a whole.

Similarly, innovative treatments are accessible for the whole population. There are no financial barriers, provided that the treatments are covered by the health insurance system.

With the implementation of the Universal Health Coverage Act, the whole population now has health coverage. On the other hand, coverage of co-financing, hospital room and board charges, healthcare professionals’ fees and therapeutic appliance prices (for eyeglasses, prostheses, etc.) in excess of the scale of charges is very uneven. It depends on whether the patients have taken out supplementary insurance and the type of coverage provided by their policies. The population category with the poorest overall coverage is made up of people in modest-income households. Since 2000, this category has covered people with incomes above the threshold for free supplementary coverage provided under the Universal Health Coverage Act. Surveys have shown that a lack of supplementary coverage is a disadvantage in terms of access to specialist medical care and dental care.

The healthcare system accounts give an idea of households’ co-financing of current expenditure on healthcare, which was estimated at 11% in 2000. Furthermore, the “Health, Healthcare and Social Protection” survey conducted every two years by the *Centre de Recherche, d’Etude et de Documentation en Economie de la Santé* (CREDES, Health Economics Research, Analysis and Documentation Centre) shows that 90% of the population had supplementary coverage in 2000, including the beneficiaries of the supplementary coverage provided under the Universal Health Coverage Act. The figure for the over-sixties was 89.2% and the figure for the over-seventy-fives was 86.1%. The survey figures on the

quality of supplementary coverage show that 40% of the supplementary health insurance policies in 1998 offered coverage for dental prostheses that was inferior to the coverage provided to beneficiaries of the supplementary insurance under the Universal Health Coverage Act in 2000.

Beneficiaries are all provided with the same coverage by the compulsory health insurance system, regardless of their place of residence. But there are local inequalities in the provision of healthcare. These are not the result of deficiencies affecting entire *Régions* or *Départements*, but there may be local areas where the provision of healthcare is deficient. Special measures, including the recent introduction of bonuses to facilitate the opening of general medicine practices in such areas, should make it possible to ensure satisfactory provision of healthcare throughout the country.

1.1.3 Challenges

France considers that, as of 1 January 2000, the Universal Health Coverage Act of 27 July 1999 eliminated the obstacles and problems that a certain number of people encountered in obtaining health coverage. Before that date, an estimated 0.25% of the population had no health coverage. The task now is to ensure that the most disadvantaged members of the population actually get access to the care they need.

Furthermore, there are no major problems with regard to care, since care is never rationed for any patient, not even elderly patients.

1.1.4 Planned policy changes

Special attention will be given to ensuring that the whole population has satisfactory supplementary coverage, in addition to the basic universal coverage. The object is to ensure that all who seek care have real access to it.

Furthermore, consideration is being given to the impact on the health insurance system of the free movement of patients within the European Union. The impact of enlargement of the European Union on the movement of healthcare professionals should also be investigated.

Targeted action ensures that the provision of care and the population's healthcare needs are taken into consideration in development planning and the organisation of government services. Measures taken include:

- Support for private practice physicians, nurses, etc. who locate in areas with deficient access to healthcare. Two ways of dealing with these problems emerged from discussions:
 - .helping professionals to open new practices by providing financial leverage if they locate in the specified areas,
 - .improving professionals' working conditions in order to overcome isolation, to pool resources and to encourage more group practices (community medical centres).

Even though these measures are initially aimed at rural areas, they should be extended to disadvantaged areas around the larger cities.

- Organising round-the-clock, on-call services on the basis of sectors within *Départements*. On-call services are the second focus of measures aimed at improving access to healthcare and doctors' working conditions. . By the end of 2002, a nationwide working group should come up with the outline of the agreement needed to tackle this problem.

Pilot projects involving community medical centres will also be encouraged in cities, suburbs and rural areas to provide around-the-clock walk-in clinics and thus limit the need for professionals to make house calls.

- Closer collaboration between local government and hospitals, more specifically through greater recognition of the role played by local hospitals and the private practice doctors and hospital doctors working in them. The specific characteristic of the 355 local hospitals in France, compared with other categories of hospitals, is that they make it possible for private practice doctors to treat their patients in a hospital environment. In most cases, such hospitals are located in rural areas and, therefore, the majority of their patients are elderly patients being treated on medical wards or in transitional care and long-term care facilities. Thus, local hospitals serve a health function and a social function. They are key sites where healthcare professionals work together. A local hospital is a community facility that often represents a major step in a graduated treatment process, either at the start of the process or after a patient's return from more intensive treatment in a major hospital.

The development of health networks emerged as an efficient new way to provide comprehensive, coordinated and personalised care that is particularly well suited to the needs of the elderly.

A health network makes it possible to decompartmentalise care. It is made up of healthcare professionals, health organisations and social welfare bodies, and its work is centred on the patients. In the case of the elderly, a health network enables a general practitioner and a social worker to coordinate all of a patient's home care, social care, in-patient treatments and outpatient treatments. This ensures better case management by preventing pointless hospital stays and by taking into account individual patients' social and family circumstances.

Legislative changes have been introduced to ensure the development of health networks, and, more importantly, geriatric health networks, which have proven their worth in pilot programmes. The new legislation introduces sweeping changes in the rules governing the establishment and development of health networks. Health networks are now legally recognised and defined. They have been made a priority for the public health system as a means of extending and improving the provision of healthcare. The administrative and financial procedures applying to such networks proved to be cumbersome. They were simplified and made more flexible to ensure the deployment and sustainability of health networks. Each *Région* now holds and manages a fungible budget for health networks.

1.2 LONG-TERM CARE

1.2.1 Access to long-term care

I – The main measures for care of the elderly

Care for the elderly covers a wide variety of facilities and services, ranging from home care to healthcare institutions. It includes such social and medical/social institutions as retirement homes.

Home help is intended to provide assistance for people aged 60 years or more with the activities of daily life and thus help them to continue living in their own homes. Depending on the beneficiaries' income, home help is partially or fully financed by retirement schemes, which paid for 75% of home help expenditure in 2000, and by social welfare benefits provided by the *Département*.

Home help services employ 85,000 people (38,000 full-time job equivalents). These services must deal with three requirements. They must organise and diversify the range of services provided (round-the-clock services), improve the training and skills of their current employees and encourage new hiring with a view to creating jobs in the community and encouraging local development.

Home nursing care services (68,000 providers in place at 31 December 2001) provide the elderly with nursing care and general healthcare. They provide assistance needed to accomplish the essential activities of daily life. Their task is to prevent, postpone or shorten stays in hospital or residential care institutions. Home nursing care is fully financed by the healthcare system.

There are some 10,300 **residential care facilities for the elderly**, where nearly 650,000 people aged 60 or more reside. The nature, legal status and size of these facilities vary greatly. They range in size from 10 beds to 600 beds and they were not initially designed to house dependent persons requiring intensive treatments. Yet, institutionalisation in such facilities is now frequently the result of a loss of the ability to care for oneself. Institutionalisation procedures and the degree of medical care provided vary greatly.

Residential care facilities for the elderly include:

- Retirement homes and sheltered housing: these are social and social/medical facilities that are primarily intended to provide permanent accommodation for the elderly. Sheltered housing consists of independent housing units with common areas that provide services to residents (meals, laundry, etc.) Home help can be provided to residents in such facilities in the same way as in private homes. Sheltered housing is considered to be a substitute for private housing.

- Long-term care facilities: these healthcare facilities house and care for persons who can no longer care for themselves and whose condition requires constant medical monitoring and maintenance treatments. These facilities mainly house highly dependent and ill elderly patients; 90% to 95% of the patients in such facilities are aged over 65. They are operated as

part of the hospital system and cannot be dealt with separately from the organisation of the overall geriatric healthcare system.

Long-term care facilities provide three types of services:

- supportive care: this responds the needs created by dependency;
- medical and technical care: preventive, curative, adaptive and, for patients in the final life stages, palliative care;
- relationship care: patients are often diminished, frail and disturbed, which means relationships are extremely important for them. The technical content of care needs to be supported by listening to patients and respecting and paying attention to their choices.

II – The implementation of recent reforms should improve care for dependent elderly patients

The Elderly Dependency Act of 20 July 2001 institutes the “Allocation personnalisée d’autonomie” (APA, individual attendance allowance) and changes the legal framework for care of dependent elderly patients aged over 60. The attendance allowance is a social welfare benefit that should enable the elderly to cover the cost of the assistance they require as a result of their loss of the ability to care for themselves, whether they continue to live at home or enter an institution. The allowance is intended to pay for the human and technical attendance that the dependent person requires and not for the provision of care covered by health insurance.

The principles can be summed up as follows:

- entitlement to compensation for a loss of autonomy, based on a personalised assessment of needs according to the beneficiary’s degree of dependency and circumstances, subject to a national scale to ensure equal treatment of beneficiaries;
- entitlement is not restricted by means testing, however the amount of the allowance is adjusted according to the recipient’s means;
- no repayment is taken from the beneficiary’s estate after death;
- the allowance is allocated and managed by the President of the *Conseil Général* (the elected assembly in each *Département*);
- the cost is shared by the *Départements*, which provide the bulk of the financing, and the Individual Attendance Allowance Fund, which is financed by 0.1 percentage points of the Social Security Surcharge (*Contribution sociale généralisée*);
- lawmakers will review the allowance following a comprehensive performance review in mid-2003.

The allowance should be paid to 800,000 highly or moderately dependent people (those in the Iso-resource groupings “IRG” 1 to 4, see appendices 1 and 2). This means 6.4% of the population over the age of 60 and includes 520,000 people living in their own homes. The take-up was expected to be spread out over two years, but the large numbers of applications for the attendance allowance received means that it will be faster. By the end of April 2002, the allowance had already been allocated to 173,000 people.

The implementation of the attendance allowance goes hand in hand with a reform of the prices charged by residential facilities for dependent elderly people. This reform was

slated for 1997, but it took a long time to draft the reform and obtain the approval of the many parties concerned.

The reform implements five principles:

- truth in pricing and charges under the facilities' three budget headings: care, attendance, accommodation;
- three levels of attendance charge, according to the degree of dependency, and coverage of attendance expenses for residents in IRGs 1 to 4 (see appendices 1 and 2), subject to co-financing provided in accordance with the recipient's means;
- upgrading of the most deficient facilities by the health insurance system;
- planned improvements in the quality of services provided to residents;
- implementation of three-way locally negotiated agreements between facilities, central government and local authorities by the end of 2003.

These reforms will be backed up by the development of community gerontological coordination units. This is an important strategic development aimed at ensuring continuity, transparency, local responsibility and coherence for public policies aimed at the elderly.

For this purpose, 25 Community Information and Coordination Centres (CLICs) were set up in 2000. In principle, each centre has a team of three social and medical professionals to coordinate community responses to the needs of the elderly after a medical and social assessment of their situation.

The centre staff should also be able to provide useful information about the services available to all elderly people. An assessment of five of the new centres carried out by Unit 500 of the *Institut National de la Santé et de la Recherche Médicale* (INSERM, Institute for Health and Medical Research) is now being concluded. The Government will use this assessment as a basis for drawing up guidelines for promoting community coordination, which is critical for the successful provision of high-quality services to the elderly, particularly for those suffering from chronic invalidity.

III – Institutional Partners for Gerontological Policies

France has a complex system for providing care for the dependent. It relies on a partnership between central government, local authorities (*Départements* and *Communes*), social security bodies and the private non-profit institutions.

The central government defines and steers policies aimed at the elderly and ensures that they receive equal treatment throughout the country. It co-finances the Community Information and Coordination Centres and shares joint responsibility for them with the *Départements*. It covers the cost of social benefits for the homeless. It also oversees social security bodies and helps to finance housing improvement.

The *Départements* have wide powers in the area of social assistance for the elderly. They grant authorisations for residential facilities for the elderly and regulate their prices. They authorise such facilities to house social benefit recipients and cover the bulk of cost of such benefits. The *Départements* have full discretion for the conduct gerontological policies and they are responsible for planning (through the implementation of a master plan) facilities and services

within each *Département*. They are responsible for allocating the attendance allowance and they finance much of the cost.

The *Communes* play a key role in providing community services that enable the elderly to continue living in their own homes.

Social Security bodies play a role in providing care for the elderly. Retirement funds finance informal home help, in addition to the services formally financed.

1.2.2 Assessment

Access to any of these forms of care is partially restricted by local availability and financing procedures. The facilities available (some 750,000 beds in all, or 168 beds per 1,000 population aged 75 or more) vary in quantity and quality, with geographical inequalities. This means that the provision of services varies from one *Département* to another and coordination between the various facilities for providing care is very rare in France.

The average national coverage rate for home nursing care stood at 15.10 beds per 1,000 population aged 75 or more at 31 December 2001. However, there are disparities between Regions, where the coverage ratio ranges from 11.11 to 20.01, along with disparities between *Départements* and within *Départements*.

Even though the supply of beds in residential care facilities is adequate to meet the overall needs of the elderly, they are not distributed evenly throughout France. The average national ratio of beds per 1,000 population aged 75 or more stands at 37.49.

1.2.3 Challenges

In addition to the regional disparities mentioned in 1.2.2, the main challenge arises from the shortage of home-help professionals. The introduction of the attendance allowance tripled the financing available for assistance for the elderly. This created the need for more home-help services (20,000 full-time job equivalents) and for upgrading existing workers' skills to improve the services rendered.

1.2.4 Planned policy changes

Recently, there have been major reforms of medical and social care for the elderly. The task now is to ensure that these reforms are implemented in compliance with a few simple rules:

. Planning and adjusting to provide the right resources in the right places, using the 2001/2005 five-year plan as a basis. This provides a coherent overall plan that encompasses the development of coordinated community services for the elderly (*Community Information and Coordination Centres*), a sustained increase in the capacity of home nursing services (capacity for 4,000 new patients in 2002, representing 6% of the capacity at the end of 2001), a tightening up of the reform of pricing by residential facilities for the elderly and the medical treatments made available in such facilities through three-way agreements (worth

180 million euros in 2002), with the introduction of the attendance allowance and benefits for the elderly who are no longer able to care for themselves (2.51 billion euros in 2002).

. **Promoting free choice of lifestyles**, while recognising the limitations on keeping the elderly in their own homes when they are suffering from substantial cognitive impairment (Alzheimer's disease, etc.)

. **Providing locally accessible information** to give the elderly and their families easy access to existing activities, benefits, care and services. This will require an inventory of the available facilities, institutions and services. The notion of one-stop service needs to be instituted to provide users with a single point of access.

. **Implementing a comprehensive approach and coordinated assessments of patients' circumstances and their social, medical and emotional needs**, so that a solution can be found locally that is centred on the patient as a unique individual and not merely the recipient of care and services.

. **Providing comprehensive care at home, accessible around the clock that combines support, attendance and care**, by developing versatile home-help/home-care services. The goal is to have these services underpin home living by providing a framework for support, attendance and care that cover health and social needs, and then making these services accessible to the elderly and the handicapped.

. **Improving the care and assistance for people with Alzheimer's disease or similar diseases** in the various aspects of diagnosis and treatment, and providing support and assistance for caregivers, ensuring respect for the dignity of patients and promoting research. The October 2001 action plan for patients with Alzheimer's disease and similar diseases covers four years and is funded by the health insurance system. It sets six objectives aimed at improving prevention and treatment:

- spotting the early symptoms,
- organising access to quality treatment,
- respecting the dignity of patients,
- providing support and assistance for patients and their families,
- improving residential care facilities,
- promoting clinical studies and research.

. **Promoting policies to support natural caregivers**, since families play a major role in caring for the elderly in their own homes, when they can no longer look after themselves. Families' devotion has not abated even though the role they play is sometimes less visible. It is important to assist and support natural caregivers by developing "respite services" such as day care centres, night nurses, temporary accommodation and support groups, which are particularly critical for family members caring for someone with cognitive impairment. The October 2001 action plan for patients with Alzheimer's disease and similar diseases is an important step in this direction. It provides more support for families by extending day care facilities and temporary accommodation capacities. Easing the isolation and preventing burnout of natural caregivers are also powerful means of preventing elder maltreatment.

- QUALITY -

2.1 HEALTHCARE

For the last ten years or so, France has undertaken an organised and structured effort to achieve ongoing improvements in the quality of healthcare in hospitals, in ambulatory care facilities and residential care facilities for the elderly. Increasing activism by users to attain recognition in the various health-related consultative bodies has influenced this effort.

2.1.1 Standards

Standards for personnel, and medical personnel in particular, were set in 1991 for certain healthcare activities carried out in hospitals, such as maternity services, intensive care services, heart surgery and organ transplants, but the quality enhancement approach also relies on other concepts, which are explained below.

. Quality development

The core of the structure for quality development in the healthcare system is the *Agence Nationale d'Accréditation et d'Evaluation en Santé* (ANAES, National Health Accreditation and Assessment Agency). The ANAES is a government agency and its board of directors includes users' representatives. It also has a scientific council and an accreditation committee. It employs nearly 200 people.

The ANAES is responsible for determining the state of the art with regard to diagnostic and therapeutic strategies in medicine and for contributing to greater quality and safety in healthcare. The Agency carries out assessments using explicitly defined methods and principles. These include rigorous analysis of scientific literature and polling the opinion of healthcare professionals (technical assessment surveys, drafting of recommendations and medical guidelines, etc.)

The Agency organises and approves "clinical practice recommendations" and it holds consensus conferences on major clinical, diagnostic and therapeutic issues. The Agency assesses working practices, provides training, conducts clinical audits and runs quality enhancement programmes. These actions cover healthcare institutions and professionals in private practice. It also participates in assessments of public health actions and programmes.

In geriatric matters, the ANAES drew up recommendations for cataract treatments, and prescription rules, along with recommendations for diagnosis of Alzheimer's disease, treatment strategies for type-2 diabetes, Parkinson's disease (diagnostic criteria and therapies) and care for patients with age-related muscular degeneration, etc.

It is currently working on clinical practice recommendations for medical treatment of strokes, incontinence, prostate hypertrophy, etc.

. Protecting patients' rights

Patients' rights are defined in the *Hospital Patients' Charter* and backed up by the *Charter of Rights and Freedom for the Dependent Elderly*.

Furthermore the *Patients' Rights and Healthcare System Quality Act* of 4 March 2002 makes patients the focus for organising healthcare. The Act enshrines the patients' human rights, such as the right to secrecy, the right to protection against any form of discrimination, the right to dignity, etc. It also guarantees the specific rights of individuals in the healthcare system (right of free and informed consent, right of access to medical files, etc.) and patients' collective rights (recognition of the place and role of users' associations in all healthcare system bodies).

The Act also includes measures aimed at enhancing the quality of the healthcare system. These include measures to ensure the competence of healthcare professionals (through continuing education in particular), measures to reform of professional bodies in order to provide better protection of complainants' rights, measures to change the organisation and financing of preventive medicine policies to make them more effective and measures to give new impetus to innovative organisational structures, such as health networks.

2.1.2 Assessment

The action of *Agence Française de Sécurité Sanitaire des Produits de la Santé* (AFSSAPS, French Agency for the Safety of Health Products) in matters dealing with drug treatments is complementary to the action of the ANAES. The AFSSAPS is a government agency. It has a scientific council and employs 880 people.

The AFSSAPS enforces the laws and regulations governing all health products. It constantly assesses the risks and benefits of the use of health products. It deploys the oversight systems associated with these assessments and manages the list of approved drugs. It supervises advertising of health claims for all products and initiates the necessary health enforcement measures or else refers cases to the proper authorities. It can hold public hearings on public health issues.

Its action related to the elderly includes recommendations for treatment strategies (for osteoporosis for example), best practice recommendations (high blood pressure, type-2 diabetes, etc.) and public information sheets on drugs. It has also joined forces with the Ministry of Health to produce a guide to prescribing for the elderly.

The ANAES has the power to implement the accreditation procedure established in 1996. This is an external assessment procedure for evaluating the organisation, operation and practices of healthcare institutions. It is aimed at promoting the development of ongoing quality policies in such institutions. The procedure is compulsory and has to be repeated at least every five years. There are three phases: first, the institution undertakes self-assessment using a set of benchmarks drawn up by the ANAES. This is followed by an on-site inspection conducted by experts named by the ANAES, who use the same set of benchmarks and draft an inspection report. The Accreditation Committee then uses this report as a basis for deciding on the level of accreditation granted to the institution.

As of the end of April 2002, the ANAES had trained 547 site inspectors. As of 31 December 2001, these inspectors had inspected 240 institutions. The 150 accreditations granted by the Accreditation Committee can be viewed on the Agency's web site. In 2002, the ANAES will carry out 400 accreditation inspections. Starting in 2003, 600 inspections will be carried out each year up, so that all 3,000 healthcare establishments have been accredited at least once by the end of 2006.

	1999	2000	2001	2002*	2003*
Number of accreditation inspections	9	66	164	404	600

* estimated

2.1.3 Promoting quality enhancements

The ANAES set up a unit to assess practices so as to establish a link between the Agency's output and improvements in professional practices. The purpose of the unit is to develop relationships with healthcare professionals so as to learn from their opinions and experience, to facilitate the distribution of recommendations and guidelines, and to provide support for the assessment of professional practices.

The unit facilitates the use of quality approaches, such as quality improvement programmes, clinical audits and quality tools. For example, methodological guides have been produced for the assessment and prevention of pressure sores and for "attenuating the risk of physical immobilisation of the elderly."

2.1.4 Challenges

The task of promoting quality is a difficult one because all of the professionals involved need to be mobilised simultaneously. But, there are many partners exercising different powers and reporting to different supervisory bodies involved in healthcare for the elderly. Starting in 2002, a new financing mechanism based on a single budget for networks should facilitate their development and improve coordination of the various healthcare professionals working with a given patient.

2.1.5 Planned policy changes

The priority for healthcare for the elderly is to strengthen the geriatrics departments and geriatric outpatient clinics in major hospitals. The objective is to make these healthcare units centres for geriatric resources and skills that work synergistically with healthcare professionals in private practice. These hospital departments will diffuse skills to other hospital departments and to healthcare professionals in private practice. They will develop preventive medicine for diseases that lead to dependency and provide training in geriatrics.

A vast hospital renewal plan called "Hôpital 2007" will be implemented in public and private hospitals to promote excellence of care and to modernise management. The plan includes a five-year investment programme, a major decentralisation and devolution effort, a reform of hospital financing; development of public-private partnerships and measures to make hospital management more flexible.

2.2 LONG-TERM CARE

2.2.1 Standards

Standards, which are official quality benchmarks that operators undertake to respect, are voluntary.

In the home help sector, the “home services” standard went into force in 2000. It covers all of the services provided by government-authorised providers. The standard aims to ensure quality services for users at every stage: receiving customers, processing requests (analysing needs and the services available), providing services in the home (preparing and providing services). The standard also defines the principles for measuring ongoing service quality improvements (dealing with complaints, assessment of service quality as perceived by users), and the skills requirements for different jobs. The certification system adopted in 2001 aims to have an external organisation verify compliance with the standard.

A “residential care facilities for the elderly” service standard is being drawn up in the residential care sector. It covers all of the services provided by such facilities: reception and admission, environment and living conditions, maintaining autonomy, care, catering, social activities, departures from the facilities. The standard also covers services provided to people who do not reside in the facility permanently, such as day care services and temporary stays.

2.2.2 Monitoring and promotion of quality

The introduction of the attendance allowance tripled the financing for assistance for the elderly. This created the need for more home-help services (20,000 full-time job equivalents) and upgrading of the skills of existing workers to improve the quality of the services rendered.

The creation of a new diploma for social auxiliaries in March 2002 is a step in this direction. The Elderly Dependency Act of 20 July 2001, which instituted the attendance allowance, set up a home-help modernisation fund and provided it with 53.4 million euros for 2002. The fund is a policy lever for upgrading the skills of home-help employees and supporting modernisation efforts and innovative experiments in the services involved.

The quality approach and improving care are at the heart of the reform of residential care facilities for the elderly. Quality targets form a key part of the three-way agreements. The agreements include a “facility strategy,” drawn up with reference to specifications that set objectives for the main quality criteria.

The facility strategy defines the institution’s master plan from which the individual plans are derived. It gives due consideration to the specific characteristics of facility residents (cognitive impairment, incontinence, final life stages, etc.) and calls for appropriate care through case management by a coordinating physician with gerontology skills. The physician’s coordinating action should improve the quality of gerontological care provided to

residents. The two main areas for coordination are inside the institution itself and between the institution and its various outside partners.

The specifications define the main recommendations aimed at ensuring quality care for residents and are based on a list of indicators. The recommendations are qualitative benchmarks that are different from technical standards. They concern the residents' quality of life, the quality of their relationships with family and friends, the quality of the facility personnel and the quality of the facility's integration into a coordinated care system.

As a follow-up to the specifications, a self-assessment tool called "ANGELIQUE" has been provided to all operators in the sector to measure the quality of care and support for residents. Most of the partners in the public sector and the private non-profit sector have adopted this tool. It is a patient-centred tool that facilities use to conduct a preliminary review of their strong points and their weak points and to define the priorities for quality improvements in their three-way agreements.

Furthermore, *the Social and Medical Action Act of 2 January 2002*, provides greater protection for the rights of users of social and social/medical facilities, through orientation guides, an elder rights charter, accommodation contracts, facility strategies and facility councils, which help ensure transparent operations and quality of care.

Providing quality solutions for the needs of the elderly calls for coordinated and easily accessible services. This is the purpose of the national network of community gerontology care coordination units called Community Information and Coordination Centres.

These centres are community facilities that provide information and counselling to the elderly and their families. They provide one-stop personalised service for all types of needs. The centres provide up-to-date documentation on all of the services available. Their task is to coordinate existing services in order to assess needs and then to draw up, implement and oversee care plans for the elderly. The centres provide information, counselling and decision-making support. They are open to everyone concerned by the ageing process and not only the financially challenged or the dependent elderly.

The coordination action covers a zone within a single *Département* defined as the users' "living area." This is the area in which most of a person's everyday and social activities take place. A "living area" may cover several municipalities or it may be as small as a specific neighbourhood of a town. Depending on local circumstances, a centre may cover a population of 7,000 to 10,000 people aged over 60 in rural areas and 15,000 in urban areas.

The network of Community Information and Coordination Centres is a public policy instrument operated jointly by the central government and the *Départements*. In keeping with this arrangement, supervision and planning take place at the local level so that Prefects and *Département* council presidents share responsibility for mobilising local partners and forging structured partnerships.

2.2.3 Challenges

Major recent reforms have affected medical and social care. These reforms have dealt with supporting the implementation of care by upgrading the skills of home help employees and by instituting three-way agreements with residential care facilities for the elderly.

2.2.4 Planned policy changes

No policy changes are currently planned, pending a review of the implementation of the reforms.

- SUSTAINABILITY -

3.1 HEALTHCARE

3.1.1 Expenditure and financing

Protection against health risks requires guaranteed access to healthcare for the whole population, in addition to the provision of quality care. In France, this is made possible through socialisation of health expenditure. Socialised expenditure makes it impossible to obtain detailed figures on expenditure and financing for the elderly (see the EPC report “*Budgetary Challenges Posed by Ageing Populations*,” October 2001). The healthcare expenditure and financing figures in the following therefore apply to all people covered by health insurance.

Health insurance financing is based primarily on employers’ contributions and a compulsory Social Security Surcharge (CSG). More specifically, the majority of the elderly receive retirement pensions, which means they are liable for the social security surcharge if their pension income is taxable.

FINANCING FOR THE CNAMTS¹ IN 2001

Employers’ social security contributions	49.3%
Social Security Surcharge (CSG)	34.2%
Central government transfers	6.2%
Specific taxes	2.6%
Recipients’ contributions	0.7%
Other	6.9%

Source: Social Security Accounts Commission Report, September 2001

The distribution of expenditure may be different for other health insurance schemes (e.g. the mining scheme). Under the terms of the Universal Health Coverage Act, people living in households with an annual income of less than 6,505 euros in 2002 do not have to pay the contributions in order to receive care under the *General Health Insurance Scheme*. As a rule, health insurance schemes are required to provide treatment for the people affiliated to them, even when contributions have not been paid, except in cases of bad faith.

Executive orders issued in 1996 introduced the system of setting a health insurance expenditure target called *Objectif National de Dépenses d’Assurance Maladie* (ONDAM, National Health Insurance Spending Objective). Parliament sets the target for each year in the Social Security Funding Act and the objective applies to all health insurance schemes. It covers all spending on healthcare by health insurance schemes, maternity schemes and work accident schemes, along with cash benefits paid due to illness and, in the case of work accidents, temporary disability benefits. Spending under the ONDAM target stood at 103.01 billion euros in 2000 and has been estimated at 108.9 billion euros in 2001.

¹ *Caisse Nationale d’Assurance Maladie des Travailleurs Salariés* – National Wage-Earners’ Health Insurance Fund, which accounts for some 85% of health expenditure.

3.1.2 Expenditure trends

France's healthcare expenditure trend slowed substantially during the nineteen-nineties, but it still showed sustained growth at annual average of 2.7% in real terms, with an acceleration at the end of the period. This means that healthcare spending growth has outstripped GDP growth since the nineteen-nineties. The average differential was one percentage point in the nineteen-nineties, but it rose to two percentage points in 2000 and 2001. National healthcare expenditure accounted for 9.4% of GDP in 1999 (source: OECD health data).

Health insurance expenditure for constant coverage under the ONDAM target increased by an average of 3.9% per year in nominal terms between 1996 and 2001.

BREAKDOWN OF ONDAM EXPENDITURE IN 2001 (ALL HEALTH INSURANCE SCHEMES)

	Year on year change in expenditure reimbursed by insurance	Contribution to the overall growth of ONDAM expenditure	Share of overall ONDAM expenditure
Private practice healthcare net of funds repaid by pharmaceutical companies	7.3%	57.1%	46.4%
Hospitals	3.3%	25.6%	38.0%
Private hospitals	3.9%	4.2%	6.1%
Medical/social services	5.8%	7.4%	7.0%
Overseas Départements and rest of world	14.1%	5.7%	2.6%
Total ONDAM	5.8%	100.0%	100.0%

Healthcare provided by professionals in private practice made the largest contribution to expenditure under the ONDAM target and accounts for 57.1% of the ONDAM growth rate. Private practice expenditure includes fees charged by healthcare professionals in private practice (doctors, midwives, dentists and paramedical professionals) and expenditure on drugs and therapeutic appliances (eyeglasses, dental prostheses, hearing aids, etc.) and cash benefits paid for sick days. The growth of expenditure on private practice healthcare results in part from the very rapid increase in drug expenditure, which has risen by nearly 8% per year on average.

Growth of expenditure on public hospital healthcare was relatively moderate at an annual average of 2.4% between 1996 and 2001. On the other hand, expenditure on medical/social facilities increased at a more rapid pace of 4% per year on average, as a result of special measures aimed at facilities for the elderly.

The impact of population ageing on healthcare expenditure growth seems to be fairly modest, even though patients' individual consumption of care increases sharply with age. The contribution of the ageing population to the growth of healthcare expenditure in real terms

was estimated at 0.3% per year in the nineteen-eighties, which is one tenth of the average annual growth recorded during the period. The contribution stood at 0.4% and 0.5% per year in the nineteen-nineties. The EPC report “*Budgetary Challenges Posed by Ageing Populations*” shows that the impact of the ageing population on healthcare expenditure (excluding long-term care) could cause expenditure to grow by 1.2% of GDP. This impact needs to be analysed in the light of the assumptions used, and keeping in mind various unknowns underlying these assumptions:

- the impact of medical advances on treatments and diagnostic possibilities for age-related illnesses,
- changes in consumer behaviour with regard to healthcare services (propensity to consume healthcare),
- the quality of life of added years in terms of morbidity,
- changes in the structure of healthcare provision to cope with the ageing of the population: expansion of certain specialties (geriatrics, palliative care, etc.), coordination between hospitals and private practice professionals, coordination between medical and paramedical professionals.

3.1.3 Cost control mechanisms

. Demand control mechanisms

The longest-standing cost control instrument focusing on demand is co-financing by patients, meaning the deterrent fee and hospital room and board charges (see 1.1.1). But the impact of this instrument on healthcare consumption is greatly attenuated since people can take out supplementary insurance. This instrument has been used to control the expenditure that is reimbursed by the health insurance system and has resulted in a greater share of health expenditure being financed by supplementary insurance schemes.

Referrals are the second instrument used to control both supply and demand of ambulatory care and hospital care. France’s very incomplete solution has been to introduce a system of referring doctors² and to develop care networks for certain diseases (e.g. diabetes and palliative care).

. Supply control mechanisms and mechanisms affecting healthcare professionals

Quantitative control of supply:

- control of the medical population: the intake of medical schools has been restricted since 1971; intake quotas are currently being debated in view of the massive number of doctors who will retire by 2010,
- hospital planning: facility locations, authorisations for major equipment purchases, Regional Health Organisation Plans (SROS) implemented by Regional Hospitalisation Agencies (ARHs) since 1996, restructurings (mainly conversions of public-sector institutions and mergers and specialisation in the private for-profit sector, cooperation and synergy between public and private sector);

² This system is voluntary for doctors and patients. Under it, the referring doctor treats patients and refers them to specialists or hospitals as required.

Price and income controls:

- the scale of fees negotiated between health insurance funds and healthcare professionals in private practice requires authorisation from the central government (administrative decisions on the value of classes of treatment and changes to the classification of treatments by government decree),
- drug prices are set by ministerial decree through comparisons with existing products, after obtaining the approval of the transparency commission, which assesses the potential of each drug to improve medical services and/or the economy.
- wages in public hospitals are set centrally,
- the approval of the central government is required for collective bargaining agreements reached in private non-profit healthcare facilities that are under the control of the public hospital system;

Incentives:

- pharmacists' profit margins on generic drugs have been aligned on those for name-brand drugs since the right to substitution was obtained in 1999,
- authorisation to write prescriptions using international non-proprietary names (INNs) since the beginning of 2002,
- availability of prescription-writing software that shows doctors the cost of their prescriptions, which will help to make professionals in private practice aware of how much their treatments cost,
- setting of a maximum activity quotas for nurses in private practice since 1992, with restitution demanded for overruns (the quota was increased in 2002),
- definition of a protective clause that requires the pharmaceutical industry to hand over some of its revenues if they increase more rapidly than the ONDAM target. Pharmaceutical companies may be exempted from handing over some of their excess revenues in exchange for discounts granted through agreements with the Economic Committee for Health Products. The discounts are calculated on the basis of sales revenue growth of therapeutic classifications and pharmaceutical groups.

Qualitative control of supply:

- Accreditation of public and private hospitals by the ANAES,
- optional peer assessments of doctors in private practice,
- best practice contracts between healthcare professionals and health insurance funds (instituted by new legislation but not yet in force),
- specification of binding restrictions on medical practices (RMOs) and best practice recommendations under the aegis of the ANAES;

Fiscal control and allocation of resources:

- This system has applied to public hospitals since 1985. Each hospital is allocated an overall budget limit. The allocation is determined with regard to information about hospitals' activity supplied by the *Programme de Médicalisation des Systèmes d'Information* (PMSI, Medical Information System Programme). This approach should narrow the wide cost differences between different facilities today, while accounting for the diversity of diseases treated and the specific characteristics of

certain institutions, such as the extra costs related to providing casualty room services or their social environment.

- Today, there are three main types of restrictions on regulation procedures: the problem of controlling expenditure other than that on public hospitals, the institutional problem of the division of powers between the central government and the health insurance schemes and the lack of micro-economic incentives.

3.1.4 Challenges

The first challenge facing the health system is to achieve the structural reforms needed to make it more efficient, while showing due respect for healthcare professionals.

The second challenge stems from demography: the provision of healthcare will need to adapt to the changing age structure of the population, as life expectancy increases and the large cohort of baby boomers ages. As was mentioned in 3.1.2, it is difficult to make long-term assessments on the effects of the ageing of the population.

3.1.5 Planned policy changes

The primary objective is to restore confidence and dialogue between partners. It is important to provide players with a clear health policy based on needs analysis and prioritisation. This will be achieved through a public health planning act. Hospitals will be covered by renewal plans, as mentioned above. Medical best practices, including initial and continuing training, assessment and accreditation, are required for ambulatory care. Drug policy should focus on improving medical monitoring. In exchange, innovation should be encouraged.

Major reforms will require close collaboration with health system players to ensure their future efficiency and to prevent a decline in the quality or the equity of the healthcare system. This is why the approach must be a long-term one.

3.2 LONG-TERM CARE

3.2.1 Expenditure and financing

Government expenditure on long-term care for the elderly came to 5.63 billion euros in 1999, which is the last reference year for all data. This figure does not include healthcare insurance expenditure on fee-for-service treatments delivered to residents in residential care facilities, which cost 1.4 billion euros.

- 4.6 billion euros was used to finance medical-treatment and long-term-care beds in nursing homes and to provide home nursing services.

- 1.77 billion euros was put into *Départements'* social relief funds, including 0.76 billion euros in benefits for dependent elderly people, 0.87 billion euros for housing benefits and 0.14 billion for home help.

- Finally, 0.49 billion euros was used for home help provided by retirement schemes as part of their health and social action.

The figures do not account for tax deductions and exemptions from social security contributions granted for creating jobs in the home.

The cost of implementing the reform of the attendance allowance, which replaces the old attendance benefit, has been estimated at 2.51 billion euros per year for 2002 and 2003. The *Départements* will finance 1.67 billion euros of the cost and the attendance allowance fund will pay another 838 million euros. The latter fund is replenished out of taxation (the social security surcharge) and contributions from retirement pension funds.

3.2.2. Cost control mechanisms

The primary demand control mechanism for long-term care for dependent patients is co-financing: coverage of room and board costs, co-financing of expenses covered by the attendance allowance is modulated according to the beneficiaries' resources (see 1.2.1).

Furthermore, social and medical/social structures providing home nursing or residential care at government set prices and with government funding are regulated through control of payroll expenses (approval of collective bargaining agreements on pay and working conditions for employees in the private sector, definition of the pay scale in the public sector) and by the annual adjustment rate applied to the ONDAM target.

Finally, pluriannual expenditure planning for medical care provided by residential care facilities and home nursing services results in the setting of annual budget limits that help to control costs.

3.2.3 Challenges

The demographic trough caused by the slump in births between 1914 and 1918 will end in 2008 and we need to be ready to cope with a substantial increase in help and care needs for very old people and the resulting financing requirements. The above-mentioned EPC report shows that the impact of the ageing population on long-term care expenditure could cause expenditure to grow by 0.5% of GDP between 2000 and 2050. However, it is difficult to assess the impact, as in the case of healthcare, because of the unknowns mentioned in 3.1.2.

3.2.4 Planned policy changes

Policy changes will result from changes in national priorities, which will occur when the time comes to cope with the challenges of the ageing population.

Appendix 1

AGGIR: Gerontological Autonomy, Iso-Resource Groups

AGGIR is the national assessment table used for allocating the attendance allowance. It is a tool for assessing the activities that elderly people carry out on their own, spontaneously and without stimulation.

The assessment table contains 17 variables, of which 10 are discriminatory variables and 7 are illustrative variables for domestic and social dependency:

- coherence (holding conversations and/or behaving reasonably),
- orientation (awareness of time and place),
- bathing (personal cleanliness),
- dressing (getting dressed, getting undressed, grooming),
- eating (eating prepared meals),
- toileting (bladder and bowel continence),
- transferring (getting in and out of bed, chairs),
- moving about inside the home (with or without a cane, a walker, a wheelchair, etc.),
- moving about outside the home (from the front door without a means of transport),
- communication (using means of communication, such as telephones, bells and alarms)
- management (managing one's own affairs, money and property),
- cooking (preparing and serving meals),
- housework (ability to do housework),
- transportation (riding or driving means of transport),
- shopping (in person or by correspondence),
- taking medicine (following a doctor's prescription)
- leisure activities (sports, culture, socialising, pastimes)

There are three values for each variable:

- A (accomplishes independently, regularly and properly),
- B (accomplishes partially, irregularly or improperly)
- C (does not accomplish).

“Regularly” refers to time and “properly” refers to the environment and in keeping with customs. “Independently” means “spontaneously and without help.” This means that the person being assessed does not need to be encouraged or stimulated by another person.

A logical classification is used to classify persons with fairly similar dependency profiles. The use of multiple resource-consumption indicators makes it possible to aggregate certain profiles, which gives six groups that consume significantly similar levels of basic care and relationship resources (iso-resource groupings or IRGs).

IRG 1 corresponds to the most dependent people and IRG 6 to the most independent. The IRGs are obtained solely by using a computer program and they depend on the values A, B or C given for each variable. The program does not correct coding errors.

. **IRG 1** corresponds to bedridden or chair-bound elderly with severe cognitive impairment who require constant attendance and care.

. **IRG 2** covers two groups of elderly people:

- bedridden or chair-bound elderly with some remaining cognitive functions, who need help with most activities of daily living;
- the elderly with cognitive impairment, but who are still able to move around (these people are often referred to as “ambulatory demented” patients).

. **IRG 3** corresponds to elderly people who have retained their cognitive abilities and some of their ability to move around, but who need help several times a day with bodily functions. Most of them need help with toileting and bladder and bowel continence.

. **IRG 4** mainly covers two groups of elderly people:

- Those who need help with transferring, but once they are out of bed, can move around their home. They sometimes need help with bathing and dressing. The vast majority of them can feed themselves.
- Those who do not have trouble moving around, but who need help for bodily functions and meals.

. **IRG 5** includes people who move around their home unaided and who feed and dress themselves unaided. They need occasional help with bathing, meal preparation and housework.

. **IRG 6** includes all people who still accomplish the discriminatory activities of daily living independently.

.....

Appendix 2 Dependency and Healthy Ageing

INSEE's 1999 survey on handicaps, disabilities and dependency showed that 800,000 people out of the 12.5 million aged over 60 are highly or moderately dependent (IRGs 1 through 4) and 390,000 are slightly dependent (IRG 5). Consequently, 90.5% of people aged over 60 are fully independent. The survey shows that half of the 530,000 most dependent people (IRGs 1 through 3) are aged 85 or more and 7 out of 10 are women.

NUMBER OF DEPENDENT ELDERLY INSEE'S HANDICAPS, DISABILITIES AND DEPENDENCY SURVEY

		Population aged over 60	of whom living in their own home
Highly dependent	IRG 1	69,000	22,000
	IRG 2	262,000	133,000
	IRG 3	201,000	137,000
Moderately dependent	IRG 4	264,000	232,000
Total IRGs 1 through 4		796,000	524,000
Slightly dependent	IRG 5	390,000	
Independent	IRG 6	11,293,000	
Total		12,479,000	

The outstanding increase in life expectancy at birth over the last twenty years, with an increase of one year every four years, has been combined with a even more rapid increase in disability-free life expectancy between 1981 and 1991 (data from the 1991 10-year health and medical care survey). Several surveys have endorsed this optimistic trend. Between 1990 and 1999, the annual gain in life expectancy without severe dependency for both men and women stood at 0.2 years at the age of 80 and 1.2 years at the age of 100. These figures are higher than the annual gains in life expectancy of 0.1 and 0.2 years at the same ages. .

The increase in life expectancy at advanced ages raises the issue of quality of life during the extra years gained. The hypothesis of a "relative compression of dependency" at advanced ages looks likely, and a decrease in the relative proportion of highly dependent elderly looks like a possible scenario.

.....