ESPN Thematic Report on Challenges in long-term care

France

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European Social Policy Network (ESPN)

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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary

Traditionally characterised by a familialist approach to elderly care, France has evolved towards a mixed model, combining public and family care. Long-term care (LTC) is a fragmented policy field associating different levels of governance and several institutional, organisational and professional actors. It is based on a cash-for-care scheme, the personal autonomy allowance (*allocation personnalisée d'autonomie* – APA). Managed at the local level by the *département* (French local authority in charge of social policies), the APA is paid, at home or in institutions, to any person aged 60 or over who needs assistance to accomplish daily living activities. At home, it finances a specific 'care plan' elaborated with a multidisciplinary team of professionals, and covers the needs which are not taken into account by the health insurance system.

Different in-kind services have been introduced since the 1970s (home-based care services, residential care, day care centres) to organise the care of elderly people. Yet, considering demographic trends – by 2060 one third of French citizens will be over 60, including almost 5 million people over 85 compared with 1.4 million in 2015 – these measures are insufficient. In a spending cuts context the sustainability of the public finances is a major challenge. The overall cost of public expenditure on policies aimed at older people represents EUR 21 billion – i.e. 1.05% of GDP. Different solutions have been adopted in recent decades to face the current difficulties and anticipate the coming demographic situation.

- Since the 2010s greater emphasis has been placed on the role of informal carers. Home-based care, which is considered as the least-cost option, cannot develop without an informal carer acting as the coordinator of the care arrangement set-up. Policy measures to support informal carers have been introduced with the objective of facilitating investment in informal carers: care leave, respite solutions, training and education.
- The priority given to home-based care also implies a restructuring of the care work sector, based on a complex price system and offering precarious work conditions.
- Better coordination of the different schemes and actors, belonging to different – health or social care – policy sectors, involving different territorial levels and a multiplicity of professionals, is another solution which has been put forward at both national and local levels. A variety of schemes have been created such as networks, pathways, coordination or integration schemes, with the objective of facilitating continuity of care for elderly people and rationalising the elderly care field.
- Prevention is also a pillar of recent policy proposals.

All these orientations inform the main objectives of the 2015 Act on adapting society to an ageing population, which proposes a move away from the medico-social perspective on old age (focused on elderly people and dating back to the 1990s) towards a more comprehensive approach, integrating all the different dimensions of ageing. The objective is not only to meet the needs of frail elderly people but also to anticipate their difficulties and incapacities by developing prevention and by adapting society to ageing. The 2015 Act also emphasises the role of local actors and the development of measures at the territorial level.

However, the measures above are considered insufficient to meet the needs of elderly people and of their families. The EUR 700 million annual budget to finance the different measures is without doubt highly insufficient. In the medium term, given the predicted demographic changes, the question of the financial operation of the LTC sector therefore remains open. The possibility of creating a fifth social security branch, which first arose in the 1990s, has come up again. The government, aware of the difficulties of creating a new user contribution, is putting a greater accent on prevention, thus anticipating and reducing the costs of dependency.

1 Description of the main features of France's LTC system(s)

If current demographic trends continue, by 2060 one third of French citizens will be over 60, including almost 5 million people over 85 compared with 1.4 million in 2015 (Blanpain, 2010, 2016). This demographic evolution is due to increased life expectancy combined with the baby-boomers' arrival at old age (Lecroart et al., 2013). Because the probability of becoming dependent increases with age, the number of elderly people (referred to as the number of recipients of the personal autonomy allowance - APA) is expected to rise from 1.15 million in 2010 to 1.55 million in 2030 and 2.3 million by 2060, corresponding to an estimated 3% of the population (Court of Auditors, 2016).

France follows a traditional familialist model that has evolved towards a mixed model with the development of specific public policies aimed at elderly people and their families (Le Bihan, 2012).

1.1 A fragmented policy field associating different national and local actors

Long-term care (LTC) policy in France cuts across different policy sectors – health, social and medico-social[1] – and involves several levels of governance: the state, regions, *départements* and municipalities. In France, the government defines national health and social policies through legislation, and different territorial levels are involved in managing and funding the two sectors. Regional and local administrations execute national health policies under close supervision from the government, whereas the decentralised French local authorities – *départements* – are responsible for social policy. In the elderly care sector, the *départements* have a statutory obligation to define local policy orientations in their territory; finance and implement the national APA; and regulate care services within their territory. In addition, municipalities can develop specific voluntary measures to support older people.

This first dividing line between the different territorial levels in the governance of the elderly sector has been reshaped by two laws. The first was the 2004 law on solidarity and loss of autonomy, which introduced the CNSA (the national solidarity fund for autonomy – *caisse nationale de solidarité pour l'autonomie*), a new national institution responsible for implementing policy measures aimed at older and disabled people[2]. The second was the 2009 health law – the Hospital, Patients, Health and Territories Act – which created a new regional institution representing central government – the ARS (regional health agencies – *agences regionals de santé*). Encompassing all existing regional and local health administrations, these regional health agencies extended traditionally health-sector-only intervention to the social care sector.

The funding of French LTC policy is therefore diverse (Vasselle, 2008; Charpin, 2011; Fragonnard, 2011). It combines social security funds (social contributions) and local authorities (taxation). According to Renoux et al. (2014), taking into account the social care dimension (EUR 9.7 billion), health insurance expenditure (EUR 11 billion), , in 2011 the overall cost of public expenditure on policies aimed at older people represented EUR 20,7 billion – i.e. 1.05% of GDP. Including household contributions, in particular for the

[1] A specifically French sector in tandem with the health and social sectors, whereas common English usage only distinguishes 'health care' and 'social care' sectors.

[2] The funds of the CNSA combine different sources: (1) a transfer of part of the sickness branch of the social security system (EUR 18 billion in 2016); (2) taxes (EUR 1.3 billion in 2016); and (3) a social contribution (suppression of a bank holiday – so-called solidarity day – EUR 2.3 billion in 2016).

cost of accommodation in residential homes, estimated at EUR 7 billion, the total budget on policy aimed at old people comes to around EUR 28 billion – i.e. 1.41% of GDP.

1.2 A specific policy measure: the a*llocation personnalisée d'autonomie* (APA) (personal allowance for autonomy)

LTC policy in France is based on a cash-for-care scheme, introduced in the late 1990s as the 'specific allowance for dependency' (1997). Focusing on situations of 'dependency', the benefit aimed at meeting the needs of elderly people who were not covered by health insurance, by helping them identify their needs and pay for care services. It was reformed in 2002 and became the personal autonomy allowance – a*llocation personnalisée d'autonomie* (APA). Managed by the *départements*, the APA is paid to any person aged 60 or over who needs assistance to accomplish everyday activities or who needs to be continuously watched over. Each level of dependency gives access to a maximum amount (Table 1), which is then adjusted according to the recipient's needs and level of income. At home, the allowance is paid either to finance a specific 'care plan' in the home elaborated by a multidisciplinary team (health and social professionals from the *départements*) after an assessment of needs, or in a residential home. The use of the benefit is controlled and the multidisciplinary teams in the *départements* are in charge of following up on the situation. The APA represents over EUR 5 billion of expenditure, of which 70% comes from the *département* and 30% from the CNSA.

Table 1: Characteristics of the APA (personal autonomy allowance)

Eligibility criteria	• At least 60 years old. • Mid to high level of dependency (Gir 4 to Gir 1) according to the national assessment grid: the AGGIR grid, which distinguishes six levels of dependency. • Proportional to the level of income: below a monthly income of EUR 800 recipients do not contribute to the funding of the care plan; above EUR 2945 of monthly income recipients contribute 90% of the funding.
Amount of the allowance	Gir 1 (highest level): EUR 1713 max Gir 3: EUR 931 max Gir 2: EUR 1375 max Gir 4: EUR 662 max
Beneficiaries	1.25 million beneficiaries in 2015. 60% of APA recipients live at home; 40% in residential homes. 45% have been assessed as Gir 4 (mid-level). 50% are more than 85 years old and 3/4 are women.

Source: Ministry of Health and Social Affairs

The APA was allocated to 1,250,000 elderly people in 2015 (8% of people aged over 60). The number of beneficiaries has stabilised since 2012, but statistics anticipate a significant increase around 2030-2040 as the baby-boom generation reaches old age. Estimates consider that the number of recipients could reach 2 million in 2040.

1.3 Different types of scheme to support elderly people and their families

A first category concerns services in the social and health sectors that propose solutions for both home-based care and residential care (Box 1). A specific care work sector has developed in France to provide professional carers in the home and in institutions. As this constitutes a key challenge in terms of qualifications and quality, we will come back to its characteristics in the second part of this report.

Box 1: Home-based and residential services for elderly people

(*1*) ***Home care nursing services*** *(services de soins infirmiers à domicile, SSIAD): 117,093 places in 2014.*

(2) ***Home help and support services*** *(services d'aide et d'accompagnement à domicile, SAAD) which include non-profit organisations and public social care services. According to the 2011 INSEE employment survey, there were 535,000 home care workers in 2011.*

(3) ***Private companies*** *in the personal services sector: these require quality certification. Their prices are established freely and subject to a contract drawn up with the cared-for person. In 2008, they represented only 4% of social care workers for elderly people (Marquier, 2010b).*

(4) ***Housing facilities*** *(foyers logements): social establishments, often run by municipalities. These facilities accommodate old people who are mostly autonomous, in small apartments adapted to minimise the risk of fall or accident. The development of this type accommodation is a priority of the 2015 Act on adapting society to an ageing population.*

(5) ***Nursing homes*** *(établissements d'hébergement pour personnes âgées dépendantes, EHPAD, and private nursing homes): in 2015, they cared for 10% of elderly people aged 75 or more and 1/3 of those aged 90 or more. The average cost of EHPAD accommodation varies from EUR 51 to EUR 71 per day (Muller, 2017). A specific allowance (social assistance for accommodation – ASH) may be allocated to the poorest residents to help them pay for the accommodation part.*

(7) ***Day care centres*** *and temporary accommodation concern 4% of elderly* people cared for.

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

A second category of schemes is related to 'coordination' and/or 'integration' measures developed to facilitate relations between the different professional actors – health and social care workers – and institutional actors involved in LTC policy in France. Within this framework, the gerontological networks were created in 1996. More recently, three different schemes have been introduced in order to facilitate continuity of care: the MAIA (method for integrated care in the sector of autonomy – *méthode d'action pour l'intégration d'aide et de soin dans le champ de l'autonomie*), the PAERPA (elderly people at risk of loss of autonomy – *personnes âgées en risque de perte d'autonomie*) and the PTA (territorial support platforms for coordination – *plateformes territoriales d'appui*). Defined at the national level and devised to support health and social care professionals in their coordination tasks, the three schemes have different focuses: prevention; complex situations; and a health and/or social care perspective. Coordination is also needed to help elderly people and their families identify existing support and locate the information they need. Local information and coordination centres (*centres locaux d'information et de coordination* – CLIC) were created to this end in the early 2000s.

A last category of schemes concerns informal carers

Although families are no longer left alone to cope with their caring responsibilities, public support is not a substitute for family care. According to the 'Handicap-Health' (HSA) survey (Soullier, 2011), 48% of the cared-for are supported by an informal carer only, 20% by professionals only and 32% by both professionals and informal carers. In other words, 8 older cared-for people out of 10 receive at least some support from their relative(s). In addition, the possibility of outsourcing a share of caring activities has entailed the need to coordinate the different professionals and the development of informal carers as 'care managers' (Da Roit, Le Bihan, 2011).

In a context of spending cuts that make the creation of new services difficult, the importance of the role of informal carers – relatives but also neighbours or friends – who deliver care and/or act as care managers of the organisational set-up was recognised in the 2015 Act on adapting society to an ageing population.

In France, public intervention aimed at informal carers is based on measures to support carers in their activities rather than financial compensation. Besides, although the APA can be used to pay a relative (except the spouse), this solution remains marginal (8% of beneficiaries, Court of Auditors 2016).

- Carer leave: concerns both elderly and disabled people.

Table 2: Carer leave

Leave	Description	Duration	Payment level	Eligibility conditions	Flexibility
Carer leave	To care for relatives with significant loss of autonomy	3 months, renewable up to 1 year	Unpaid	To have worked at least 2 years	Can be used for a part-time period
Family solidarity leave	To assist a dying relative	3 months, renewable once	Unpaid but daily allowance (EUR 55/day max 21 days)	Granted to all employees	Can be used for a part-time period

- Respite care has been improved with the development of day care centres, and a 'right to respite' was introduced in the 2015 Act on adapting society to an ageing population, with financial support of up to EUR 500 per year.
- Training has been available to informal carers since 2009 (2009 Health Law).
- Information services: a national web platform was created in 2013; CLICs also give advice to families.
- Respite platforms: propose advice and solutions to the cared-for and their carers.

1.4 The Act on adapting society to an ageing population

The 2015 Act on adapting society to an ageing population marks a turning point in the conception of 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. The left-wing government of the time drew up an ambitious law that tackled the issue of ageing in a comprehensive manner, integrating the notions of healthy ageing and prevention (Delaunay, 2017). It is based on three pillars:

1. anticipating loss of autonomy, which comprises financing action on preventing and combating isolation among old people (EUR 185 million in 2017);
2. adapting society to ageing, which includes the launch of a plan to: adapt 80,000 private housing units by 2017; renovate residence-accommodation (*foyers logements*), renamed 'autonomy residences' (EUR 84 million in 2017);
3. supporting older people facing loss of autonomy, with a priority given to home-based care (EUR 460 million in 2017).

2 Analysis of the main long-term care challenges in France

2.1 Assessment of the challenges in LTC

2.1.1 Access and adequacy challenge

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

- The services on offer lack transparency due to the high number of existing measures. The health and social care sectors are compartmentalised, resulting in separate circuits and frequently different operating methods. Users sometimes find it difficult to fathom the system and identify the most appropriate solution.
- The cost of social care services. Although health services are financially covered by the health insurance system, families are often faced with paying considerable additional costs for social care services. In residential care homes, the average remaining cost to be met by residents is estimated (Fizzala, 2016) at between EUR 1470 and EUR 1758 per month (excluding social housing benefit for the poorest); in the home, APA beneficiaries pay on average EUR 80 per month from their care plan (Fizzala, 2016).
- Territorial disparities. Although national legislation exists, measures are carried out locally by *département* councils and ARS, with clear variations between one territory and another. Rural areas in particular offer fewer in-home care services and nursing services than urban areas.

2.1.2 Quality challenge

In France, the development of a specific care work sector has two main objectives: to support elderly and disabled people and reduce unemployment through the development of a new professional activity sector. These two objectives have proved contradictory, as the quantitative dimension of the second objective is not always matched with quality (Le Bihan, Sopadzhiyan, 2018). The elderly care work sector is part of the larger sector of 'personal services' (*services à la personne*), which focuses on the volume of workers and includes any person providing services to individuals. Although a specific diploma was created at the end of the 1980s (reformed in 2002 and 2016 to improve training), home-based care is still characterised by a low level of care worker training. According to statistics (Marquier, 2010), 62% of care workers have no diploma from either the health or social sector. Besides, the existence of three different forms of care work relationship, combined with three different hourly rates, creates complexity: the '*prestataire*' system (service provision, by which the care user is relieved of any employer obligation), the '*mandataire*' system (which proposes partial delegation of administrative tasks) and the 'direct employment' system (which is the cheapest solution but also the most binding, as the care user is responsible for both recruiting and managing the working relationship with the care worker).

A second issue is the employment situation of professional care workers. This is characterised by precarious working conditions and insufficient training, which explains why the sector remains unattractive (Le Bihan, Sopadzhiyan, 2018). The majority of care workers are employed on a permanent contract, which can appear to be a secure form of employment. However, this employment stability is only apparent because of the high prevalence of part-time work and situations in which a care worker has several employers. Care service work still does not provide full-time work, with fewer than 30% of home care workers employed full time (Marquier, 2010). The average length of the working week is 26.1 hours over 4.9 days, with home care workers attending to 6.5 different people in one week – 5.4 of whom are elderly. The average wage is EUR 832 per month, but monthly earnings vary significantly according to whether care workers

are employed full time (EUR 1190) or part time (EUR 717), and whether the structure they belong to is public or private (Nahon, 2014).

The quality of residential care is also currently being questioned. A specific programme 'Quality of life in EHPAD' was elaborated in 2010. It identifies good professional practices in order to improve residents' quality of life. But the current difficulties faced by institutions do not facilitate the implementation of such a programme. Despite an increase in the number of residents, staff ratios for care remained the same from 2011 to 2015. Combined with a pricing reform that is complex to put in place, nursing homes currently face considerable difficulties. Strikes by EHPAD staff have been organised since the end of 2017.

Finally, the question of the conditions in which informal carers provide care has been raised, and measures supporting carers in their activities (information, counselling, training, support groups) and encouraging the empowerment of carers (Le Bihan et al., 2014) have been introduced.

2.1.3 Employment challenge

This challenge is primarily related to the work-life balance issue. The HSA survey (2008) carried out by DREES estimated that 4.3 million carers regularly help one or more relative over 60 (Soullier, 2011). These carers are aged 58 on average and are most frequently women. The latter represent 57% of carers of older people, but the proportion increases to 74% with the level of dependency of the cared-for (Dubois, 2011). Considering the increase in the participation rate of women from 50 to 64 years old in the labour market (up to 61.1% in 2015, see INSEE, 2017), the issue of work-life balance is particularly acute for women. The HSA survey also shows that 46% of carers are retired, 39% have a job, 6% are unemployed and 9% do not work. Care investment has an impact on work in terms of stress and tiredness. 11% of carers have reorganised their professional lives by reducing their work hours[3], resorting to sick leave or changing jobs.

Although there are no specific data on how many working carers take advantage of carer leave to achieve a satisfactory work-life balance, a recent survey (Sirven et al., 2015) suggested very low-take up of this type of leave, at only 7% of interviewees. Most carers (between 50% and 80%) were unfamiliar with the leave provisions. In fact, carers tend to use standard leave (sick leave) or even annual leave, rather than specific carer leave, which is either unpaid or with a low allowance (Table 1).

The development of a home care sector in relation to employment policy is a second issue. Although the main objective is to meet the needs of families, the increase of the number of home care workers since the 1990s has also aimed, independently of the quality of the supplied service, at reducing unemployment by contributing to the development of the so-called 'personal services' sector – including childminders and domestic cleaners (Le Bihan, Sopadzhiyan, 2018; Devetter, Lefebvre, 2015).

2.1.4 Financial sustainability challenge

Three main orientations can be identified, with an emphasis on the involvement of local actors.

- Improving coordination of existing schemes, organisations, institutions and professionals has been high on the political agenda during the last decade. Since 2010, three different schemes have been developed with the common objective of facilitating relations between social, medico-social and health institutional and/or

[3] The resort to part-time work, particularly for women (Dubois, 2011), is confirmed by EUROSTAT data which show that in 2016 24.9% of women (aged 15-64 years old) worked part time because they cared for children or for a disabled adult and 16.4% because of other family responsibilities.

professional actors at the local territorial level. These are the MAIA, introduced in the 2008-2012 Alzheimer Plan and concerning 60+ elderly people with complex needs; the PAERPA scheme, created in 2014, which is a specific health pathway combining a range of tools in a prevention perspective targeting elderly people aged 75+; and finally the PTA scheme, which is not population-based. Yet the successive creation of these different schemes has introduced confusion for the actors concerned and for care users.

- Developing prevention is a priority of the 2015 Act on adapting society to an ageing population (see 2b).
- Using technological solutions: although investment in new technologies as a solution to support elderly people and their family is recent in France (end of 2000s), it is currently presented as a priority. The definition of what is referred to as the 'silver economy' sector encompasses a broad spectrum, from the most sophisticated safety technologies and robotics to the simplest technical aids and remote assistance services for old people's housing and mobility. It is presented as a support for home-based care that will also have an impact on growth, industrial development and employment.

2.2 Assessment of recent or planned reforms (how they address the challenges)

The 2015 Act on adapting society to an ageing population was devised to respond to the different challenges identified above. Two years after its implementation, the first assessment report (Firmin Le Bodo, Lecoq, 2017) underlined the importance of the comprehensive conception of ageing proposed in the law. It also identified the emphasis on prevention and coordination, and the introduction of a special body – the 'funders conference to prevent elderly people's loss of autonomy' (*conférence des financeurs de la prevention de la perte d'autonomie des personnes âgées*) – to manage coordination at the local level as a key response to the challenge of sustaining the elderly care sector. Focused on prevention and managed by the *départements*, this conference gathers all institutional and professional actors involved in the elderly care sector and has three main activities: to establish a diagnosis of the needs of the over-60s in the country; identify local initiatives; and define a coordinated programme to finance individual and collective action to prevent the loss of autonomy. It is currently being trialled in 24 pilot *départements.* Analyses also insist on the positive impact of some measures on the LTC sector. For instance, a revision of APA amounts has entailed a significant reduction in care users' contributions (3 to 9% of the global cost of the care plan). Finally, the formal definition of an 'informal carer' can be considered as a step forward, as it constitutes a genuine recognition of the investment made by this type of carer.

Yet several difficulties can be identified, as follows.

- Concerning informal carers, the measures proposed in the law are considered insufficient: care leave is unpaid, and the right to respite is rarely taken up due to lack of information and restrictive access conditions. Some analysts (Maisonnasse, 2016) also argue that the 2015 Act does not consider the gender dimension of informal care.
- Although funders conferences are clearly the object of financial investment (EUR 102 million in 2016 and EUR 104 million in 2017), they are not yet fully organised. One concrete result is the establishment of field-level coordination, but the means for selecting measures to finance are not yet clear.
- Maintaining older people in the home has been put forward as a priority response to family wishes and to the financial challenges of caring for older people losing their autonomy. However, this requires reorganising care services in the home, which have been subject to several years of upheaval. This new organisation, which is still pending, was announced in the 2015 Act and was the object of a

report (Labazée, 2017) that gives guidelines for setting up a new economic model of care services.

- In addition to setting out a national action framework, the 2015 Act underlines the frontline role played by départements in home care. They are responsible for reviewing aid packages and organising funders conferences. However, it is already clear that the départements do not always apply the law in the same way, which introduces territorial disparities.
- The final question, which cuts across several areas and constitutes the weak point of the 2015 Act, is the issue of funding the proposed policy. The EUR 700 million annual budget is without doubt highly insufficient. In the medium term, given predicted demographic changes, the financing principles of the LTC sector therefore remain open. The possibility of creating a fifth social security branch, which first arose in the 1990s, has come up again. The government, aware of the difficulties of creating a new user contribution, is putting a greater accent on prevention, thus anticipating and reducing the costs of dependency.

2.3 Policy recommendations to improve the access and adequacy, quality and sustainability of the LTC system(s).

- Pursue coordination efforts taking into account the different existing levels. This concerns professional, institutional and political actors and takes place at territorial and central levels. At central level, national coordination of the different measures is based on competencies relating to several sectors of public intervention. Coordination should therefore also take place between different ministerial departments in order to avoid fragmentation or overlapping measures. At local level, different coordination measures exist (MAIA, PAERPA, PTA, in addition to gerontological networks) but the numerous bodies and operational teams make the general system difficult to fathom. Simplifying these measures therefore seems necessary. The various notions used to describe the measures also need clarification, i.e. coordination, integration, channels, networks and pathways. The latter notion seems to be currently employed, along with convergence.
- Make the services on offer easier to understand to help families choose between the numerous existing measures. This involves better local organisation of information.
- Reorganise home care services by distinguishing the following two priorities: a reform of the complex pricing system; and an improvement in working conditions for care workers to make the sector more attractive.
- Develop support for carers with a broader range of solutions to respond to different needs, including: the possibility of respite leave; paid leave of different durations (e.g. leave for family emergencies to cope with unexpected events); and more flexible work time (adaptation of working hours, option to work part time).

3 Analysis of the indicators available in France for measuring LTC

Different bodies – DREES; the Directorate for Research, Studies, and Statistics (DARES); and the National Institute of Statistics and Economic Studies (INSEE) – carry out quantitative and sometimes qualitative studies to collect information on the LTC sector and analyse the measures and policies in place[4].

[4] The key findings of the different reports and research studies mentioned here are referred to in section 1 and 2 of this thematic report.

The useful data primarily concern the situation of elderly people who are losing autonomy. As pointed out by the Court of Auditor's report of July 2016, most of the information available is relatively old. It comes from three main surveys: the 'Handicaps, Disabilities and Dependency' (HID) survey of 1998-1999 and the 'Handicap Household Health' (HSM) and HSA surveys carried out in 2008. The new CARE survey was launched in 2015 by DREES. It has three main objectives: to monitor changes in dependency; estimate the burden resulting from dependency; and evaluate the extent to which family members are involved in caring for elderly people. Exploitation of the data collected has only just begun (Brunel, Carrère, 2017).

Studies were conducted based on these data, investigating the roles and profiles of both informal and professional carers, as well as their articulation (Soullier, 2011, 2012). The cost value of informal care was also underlined (Davin et al., 2015).

In addition to these surveys designed to assess the everyday living conditions of older people losing their autonomy and of their families, and thus to anticipate their needs, the following data exist on the services available.

- Surveys on residential establishments for old people and for dependent old people carried out by DREES every four years, monitoring the number of residents and living conditions in EHPADs (nursing homes) (see e.g. Muller, 2017; Calvet, 2016; Volant, 2014).
- Surveys on home care services, which are subject to many more problems. This is because analyses specifically focusing on carers of the elderly are out of date. They are based on data from the 2008 DREES survey of in-home care workers (Marquier, 2010). The most recent data (e.g. INSEE surveys) relate to the much broader sector of personal services (2011 INSEE employment survey). The Court of Auditors (2014) also estimated the number of care workers based on DARES data, but this too relates to workers in the personal services sector as a whole without specifically distinguishing workers caring for the elderly. The different surveys underline the precariousness of the working conditions of home care workers; the heterogeneity of the profession of home care worker; and the complexity of the sector of home care service, which combines different funding (public support and financial contribution by families). They point to the necessity of restructuring home-based care (see in particular Labazée, 2017).
- A survey on home care nursing services (in 2008) stressing the inadequate supply of nursing (Bertrand, 2010).

The APA has been regularly monitored by DREES since its creation in 2002. Thus data are available on the number and profile of beneficiaries and on the type of care plans (Couvert, 2017). Analyses also investigate the financial coverage of elderly people at home, based on the allocation of the APA (HCFEA, 2017).

In a more comprehensive manner, the funding of the LTC sector is the object of specific attention. In 2011, a report was produced exposing the frailty of the LTC system in terms of sustainability and adequacy (Fragonard, 2011). It assessed precisely the costs related to dependency and underlined the need to reform the system in the context of the increasing number of elderly people. The Court of Auditors regularly publishes reports (2014, 2016) and DREES recently put together a brief on this question (Fizzala, 2016). Finally, the French Minister of Solidarities and Health has launched a reflection process on the funding of LTC sector. The creation of a fifth social security branch, which has been regularly put forward since the 1980s, will be examined and alternatives explored.

Lastly, analyses carried out by INSEE and/or DREES include demographic forecasts and can be used to evaluate the increase in the number of dependent people (Blanpain, Buisson, 2016; Lecroart et al., 2013) and thus anticipate future care needs.

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