



Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Governance and Finance of Long-Term Care

National Report France

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1 Background

Building on learning from earlier research phases (Kümpers et al, 2010; Nies et al, 2010; Triantafillou et al, 2010), this element of INTERLINKS focuses on the governance and financing of long-term care systems. Taking place primarily in year 2 of the project, this contribution has to strike a balance between, on the one hand, providing a contextual analysis to facilitate learning from this earlier work on prevention&rehabilitation, quality assurance and informal care in LTC and, on the other hand, to understand more about how to incentivise and embed good practice in these three domains.

2 Key contextual factors

In France, policy regarding disability linked to ageing is the latest extension of the overall social policies embedded in its welfare state. It has gained a large public recognition although this extension has resulted in a superposition of institutions and providers operating within contradictory logics so that this policy is yet not stabilised and largely unachieved. The complex history which explains the design of the actual governance and financing of LTC services state for older people can be summarised as the result of four factors:

- First, since the set up of the French welfare state following the end of World War 2, there exists a strong commitment to the principle of a mandatory national Health insurance system with entitlement based on work, financed primarily through social contributions and originally governed through a bargaining process between worker's representative unions and firm's umbrella organisations and thus based originally on a Bismarckian approach. The French health system has also historically tended to have a more curative than a preventative approach with a use of resource-intensive services resulting in strongly technology driven system based on extensive use of acute hospitals. Much less attention has been given to the community based care sector, poorly organised (as opposed to what is coined in many countries as a primary care system) and also until the beginning of the new century weakly regulated by the national sickness fund (CNAM). The community care sector used to (and continuing) to be led by independent and pay fee for services GPs and specialists operating out hospital with their unions dominantly in charge of the negotiation process with the NSF in order to define the national collective agreement setting the professional rules regulating their activities. The escalating health costs judged to be the result of this process led all governments since the beginning of the eighties to constantly interfere in this process, leading to a rather incoherent balance in the governance process as state approval was mandatory for any outcome of the negotiating process before it can be implemented. Two changes illustrate this growing power of the state: First, the introduction in 1993 of tax-like contributions (CSG) and in 2004 the institutional reform giving more latitude to the director of the sickness fund's executive body to design policies more aligned with the government position than to its own board one.
- Second, the French health system is characterized by a strong division between the health (cure) and the social (care) system of LTC, located at their interface, not being recognised as a specific subsystem. It began only to emerge twenty years after the welfare state construction that took place between 1945 and 1975. Until then, it consists only in poorly financed and thus developed services targeting the need of the more deprived fraction of the elderly population with low income

(pension)/asset and most likely to be located in poorly staffed residential homes. But attention to the care of disabled elderly (defined through the age barrier of 60+) continues to remain weak when compared to their 60-counterpart (coined as handicapped). It is the 1975 law which set this 60 age barrier and set up the means to develop a specific and rather comprehensive network of providers and services focusing the 60- disable population but at the price of very limited social integration. So with marginal exception, it is only after 1995 that the frail elderly population (60+) received more consideration in term of a targeted policy. This evolution was marked by the law of 2002 which defined the governance and regulation of LTC providers, by the law of 2004 which gave major responsibilities for LTC to local authorities and in particular to general councils (executive body of the local authority called “department” to plan and regulate social services provided). Finally the 11/02 2005 law (called law for fair chance”) aim to reconcile the way both (60-/60+) disabled population were to be managed. A specific national agency called CNSA) was created in 2006 in order to facilitate the convergence of disability policies independently of age. Two reports (Gisserot, 2007; CAS, 2006)) and two plans set the main principles, goals and means of this policy which has been caught into strong difficulties since 2008.

- Third, since 1987 there has been a constant trend by the government to develop as a major part of employ policy the market of ‘personal services’ considered as an opportunity to create new jobs for unskilled and frequently unemployed persons while in the same time trying to clean the grey market. Numerous various fiscal incentives and social charges exemptions which existed for services focusing elderly were boosted and enlarged first through the “Borloo law” of 2005 to be followed by a second one in 2009. These financial incentives were conceived to help any person to access all type of services delivered home and whatever services was a response not only to care needs but also to a long list of leisure based services (such as computer training or music lessons). Even if the development of “direct services” at large is more to be considered as an employment policy than a policy specifically targeting the frail ageing disabled population, it had and still has a strong impact on it but at a price which does not carry the expected outcomes for elderly (Cours des comptes, 2010; IGAS, 2010).
- Fourth, this “employment policy” was followed ten years later (1996) by the adoption, both in the health and social care sector, of a market-based approach for reforms. Competition between providers since the last 15 years is an important dimension of health social policies as new regulations have allowed private for profit providers organisations to enter the market of the frail older population as they were considered to be a mean of improving standards and value for money by challenging the claimed inefficiencies of the long standing public and private non-profit providers. Another claimed objective was, by widening their choices, to put users more in control of their lives not only by enhancing the market of “personal services at large” but to give them more choice based on self determination. The newly created (2000) attendance allowance called APA that was initially conceived as a tool to give access to services in kind was also partly conceived as a cash benefit to directly employ a domestic worker which could also be any family member.

So even if there still remains a strong commitment for publicly funded health and social services rather comprehensive and accessible when compared to other European countries, in many areas of the LTC system, services are more and more provided by a mixed economy of public, private and voluntary sector providers. In the same time, there is a strong debate about the way to modify the actual public disability scheme, based on the care attendance allowance “APA”, in order to design a new funding system where voluntarily (or obligatory) disability insurance schemes, individually based or through firms, would complement or supplement public money (see tensions).

3 The governance and financing of long-term care services for older people

French welfare state historically assumed a strong divide between the health and social sector. So as by definition LTC encompass both of them, its governance and financing structure can be analysed as resulting of a mix of Beveridge and Bismarckian features. Also governance and financing of France LTC system takes place across different national, regional and local political levels, each one with its own responsibilities but with still some gaps and/or redundancy between them.

3.1 Governance

As seen in the previous paragraph, laws and national regulations regarding LTC are decided at national level with the two more concerned ministries being the health and the labour ministry and their respective central department (DGOS, DGS) and linked national agencies (CNSA, HAS, ANESM, ANSP, CNAV, CNAM, CAF) with some contribution from the finance one. Up to April 2010 and regarding the health sector, all acute and rehabilitation hospitals and hospital at home (HH), whether public or private not or for profit, used to be were regulated at regional levels by the regional hospital agencies (ARH) under the supervision of the health ministry and with no legal involvement of the regional political authorities. GPs and specialists were regulated by the national public sickness fund (NPSF) with more and more state involvement. Nursing agencies were under the remit of the national health agencies and the regional body of the health ministry (DRASS).

According to the new HPST law passed in April 2010 the regional hospital agencies were replaced by regional health agencies which were supposed to integrate all previous regional regulatory bodies with all their legal power and thus to be responsible of both the health and social sector. But the balance of responsibility and power between these two entities does not appear that clear: Regarding the social sector (coined “secteur medico-social”), while ARS are responsible for organizing the overall provision of care, it still remains under the remit of the General council to plan and regulate the delivery of home help and personal care by “entitled to” providers and professionals whether in home or in nursing homes. For in order to be funded and deliver their services to the target population of frail elderly, all providers, whether they run residential homes and/or home care agencies, must be “quality acknowledge” by local authorities (general council) and/or by the state representative) at departmental level. On the other hand, as classical planning has been replaced by tenders in order to choose new providers who will be authorised to enter the market of older people and as these tenders are defined and regulated by the agencies, it is not clear which regulating body will be responsible to decide what type of providers is needed and on which basis he will be chosen as the law provides no legal or practical guidance regarding how to link the two entities. Finally, user’s and families advocacy groups have weak recognition and do not participate in the political negotiation process.

3.2 Financing

Each year, the parliament vote a prospective health budget (ONDAM) from a fraction of which difficult to isolate) is used to cover LTC health related service. In the same way, a specific prospective LTC budget (ONDAMMS) covering “social related services” is voted covering also handicap expenses. Also as Health and social care have separate raising fund scheme, this funding by “silos” makes a valid estimate of

public expenditure on long-term care for older people difficult to calculate as LTC services cover both domains.

3.2.1 Funding of health related services

All people who are *sick* and have *medical needs* linked to acute curable or chronic diseases and who need a regular medical follow up), are entitled to medical services reimbursed by the NPSF but with co-payment not linked to revenues. Only for specific chronic conditions (ALD) hospital and ambulatory health services “directly linked to the illness” are free at the point of delivery (even if for some of these ALD patients (34 groups) some may incur an important amount of out of pocket money).

Funding for health related services comes from social security contributions linked to salary work, and from a definite portion of a more extended “social tax” based also on other types of revenues. The national public health insurance agency (CNAM) reimbursed 75.5% of total health related services expense in 2009 (HCAM),¹ encompassing services delivered by acute hospitals; intermediate care hospitals for rehabilitation as well as Hospital at home delivering care to severely chronically ill and/or disabled. Ambulatory physicians services as well as technical and personal nursing care delivered by self employed nurses or nursing home agency (SSIAD) at home are also covered by this scheme. CNAM covers also all medical or nursing care services delivered to older people in nursing homes. A fraction of the remaining costs (13% of overall expense) of these services are covered by a “voluntary based” system of competing (for and not for profit) insurances, with 85% of the population beneficiaries (HCAM, 2010). A specific publicly funded scheme (called CMU regarding costs covered by the CNAM/CMUC for complementary insurance) enable people with revenue below a defined threshold level (€650 in 2010) to be reimbursed for health related services (the total amount 5% of all health related cost).

Only 0.1% of the population was not publicly insured in 2010 while 9% did not benefit from a complementary insurance thus leading to an average out-of-pocket spending of 8%. So even if regarding publicly reimbursed health related services, this scheme can be considered as universal, its access is not really free at the point of delivery with for a not insignificant portion of the population more and more difficulties in accessing specific publicly delivered services (surgery and out-patient specialist doctors) leading to a much higher level of out-of-pocket spending which overall amount €2 billion in 2008 (HCAM, 2009).

3.2.2 Funding of social (disability) related services

Any person older than 60 may apply for the public attendance allowance called APA. But it is only when they have been assessed as having *social care* needs through a national tool called AGGIR that they can benefit from related personal services (ADL, IADL) and also of technical services such as housing accommodation; technical devices etc.). An older person with needs linked to disability will be (partially) covered by the publicly financed allowance APA if they are considered as fairly disabled (located in Group 1 to 4 according to the AGGIR ranking). APA entitlement is thus needs based and not means tested, but it comes with a co-payment linked to the user’s revenue and also with a ceiling amount by category. In 2010, the public funding of the care attendance allowance APA comes from the national

¹ http://www.sante.gouv.fr/htm/dossiers/hcaam/rapport_2009.pdf.

health insurance fund (62%), the state (5%); from the CNSA (11%) and from general council (22%). All collected funds are gathered and redistributed to the general councils by the CNSA.²

A means-tested social assistance may also provide funds if the beneficiary and his family have proven they are unable to pay for the costs of entitled services or housing costs. For people less disabled (GIR5) the national retirement agency (CNAV) provides some funds for home help and also for housing accommodation costs while CNAM through its social programs helps a fraction of the deprived population. For these “social services (which are services linked to disability)” there exist at CNSA level a redistribution scheme that aims to bring more geographical equity in the provision of services at local level and based on a formula taking into account objective criteria that reflect expenditure needs (e.g. demography and socio economic structure in terms of wealth and providers concentration).

Health and social care agencies and professionals have yet to overcome a series of barriers – organisational, financial, legal, but also professional and cultural – if they wish to work together more effectively (Table 1).

Table 1 **The health and social care divide**

	<i>Health Care</i>	<i>Social Care</i>
<i>Accountability</i>	National (to the parliament))	Local (to elected general council but also at national (state) level)
<i>Policy</i>	Overseen by the ministry of health alongside with the labour and finance ministries and by the national health sickness fund	Overseen by local Government and ARS although framing social care policy is the responsibility of the health ministry.
<i>Charges</i>	Universal access but with not revenue linked co-payment at the point of delivery except for specified chronic diseases (ALD)	Universal access with entitlement according to needs but with co-payment level linked to revenue + family obligations to substitute older people in case they cannot pay.
<i>Boundaries</i>	Weak gate keeping system for specialist access (ambulatory and hospital) as GP registration not mandatory + medical order to get technical nursing care.	No clear boundaries between the regional ARS and the departmental political level (General councils).
<i>Focus</i>	Individual (medical) cure	Individual care taken in a wider context (family, neighbours, social network and integration ...)
<i>Culture/training</i>	Strongly influenced by medicine/science culture. Enhanced advocacy by patients associations.	Still more influenced by medical than by social+culture. Lack of power of user’s advocacy group and weak recognition of their voice (whether individual or collective).

² <http://www.dependance.gouv.fr/Consulter-les-documents-des-quatres.html>.

3.2.3 Reimbursing for LTC services

Based on accounting court estimation methods (Cour des comptes, 2010), overall public budget for LTC services has been estimated in most recent studies (May 2011)³ to amount €24 billion corresponding to 1.3% of GDP (to be compared with 10.5% for overall health expenses).

The specific contribution of the CNAM for reimbursing health related services was estimated to amount €14 billion) including hospital and ambulatory services (€4 billion).

Publicly covered cost of services specifically linked to disability was estimated €10 billion among with APA's expenses amounted €5.3 billion. State contribution amounted €1.5 billion mostly through fiscal and social charges exemptions. Public contribution of various sources to "housing costs" and "non human help" amounted €2.5 billion.

Publicly funded social services coming from the LTC care attendance allowance APA are far from covering all real needs: As there is a ceiling for each disability group, APA does not cover all services embedded in the care plan (30% gap in average). As the latter also does not encompass all real needs, it is up either to the individual or his family to cover the remaining from his own income or savings or his asset. It is difficult to estimate the additional out-of-pocket expenditure coming from the non APA covered services included in the care plan. It is even harder to quantify how much, households spend on "undocumented" care (for services not included in the care plan but corresponding to real needs).

Nevertheless it has been estimated⁴ that overall out of pocket money for users and their families linked to disability amounted €8.4 billions among which a large amount (€4.8 billion) are used to pay a fraction (58.5%) of overall housing cost (€10.1 billion) in nursing homes. Overall out of pocket payments linked to "social services" amount to €0.9 billion for nursing home residents and €0.8 billion for people living at home but with large inequalities regarding revenues and geographical locations. To these private one should also add the "hidden costs" corresponding to all caring tasks (services in kind) delivered by informal carers, 90%) being family carers and estimate to be €9 billion (Accounting court, 2010). Health related services costs paid by out of pocket money has been estimated to be €1 billion. So overall private costs amount to €18.4 billion. Finally if one add all costs (public and private) the real cost of LTC services amount €42.4 billion which represent 2.3% of the GDP and fall just short behind the average level of LTC northern countries public budget.

³ <http://www.dependance.gouv.fr/Consulter-les-documents-des-quatre.html>.

⁴ <http://www.dependance.gouv.fr/Consulter-les-documents-des-quatre.html>.

4 Key barriers to joint working

4.1 Structural

As suggested above, services for older people in France are fragmented between health and social care systems, each with different legal and financial frameworks, geographical boundaries, accountability mechanisms and cultures. However, even within the health care system, responsibilities for an older person's care pathway is split between multiple and independent providers: general practitioners and specialists not frequently working side by side; mental health services provided by private or public providers, on different organisational and financial basis; secondary and tertiary care (provided by hospitals, whether private or public). Adult social care also tends to use separate teams for frail older people and for disabled people of working age, so there can be additional structural barriers. Other services that play a role in supporting older people (for example, housing, transportation, leisure etc.) are frequently provided by local authorities, but not coordinated with the care sector. So the health and social care divide continue to be an issue that the new regional health agency (ARS) may help to solve (see good practice).

4.2 Procedural

While health related services (nurses technical services for example delivered by free nurses) continue to be available for almost all users with still limited financial barriers at the point of delivery, social care is governed by a national framework with universal access but with eligibility based on needs and is subject to means-testing for co-payment.

Also Arising out of separate organisational structures and legal frameworks, different social care agencies providing care whether individually or through their umbrella organisation, have different policies and procedures, including approaches to terms and conditions, pensions etc. So even in home agencies providing both health and social based services are not integrated as each type of services is delivered by different professionals and while establishing a common plan care is possible but remains a difficult task, it is even more difficult to coordinate providers at the field level. Also for providers organisation managing both home agencies and nursing homes, it is not possible to transfer residential staff in order they provide home care and vice versa. Also discharge planning from hospital is usually not working or efficient as working jointly between home front-line staff with their hospital counterpart proved to be difficult (for a good practice example see COPA)⁵.

4.3 Financial

Over the next few year it is recognised that demographics trends and in particular the ageing of the population will have an impact on LTC care higher than in the past. However, in the growth of LTC expenditures, it is not age "per se" that constitutes the main cost driver, but the intensive use of expensive medical technology to treat illnesses leading to disability. Securing the health care financing scheme by controlling service's costs is thus of paramount importance for sustaining the LTC system as their weight supersede social services costs linked to age and disability.

⁵ <http://interlinks.euro.centre.org/model/example/CoordinatingCareForOlderPeopleCOPA>.

In the French long-term care system, public costs related to disability are financially through the APA attendance allowance scheme which enables older people to access benefits whether in-kind or in cash. So the French system is both demand and supply driven. In such a system, budgetary pressures to control the overall APA amount can be done either by regulating the supply-side (i.e., the amount of professional care), and/or by tightening eligibility criteria and also the basket of reimbursed services. With in practice, both options being used.

Regarding the supply side after during the ten years following 1999, although an important effort to enhance the number of beds in nursing homes and/or the training and education level, skills and competence of home care agency's staff was done, there still exist limitation in access, with important geographic disparities that CNSA redistribution program try to reduce them.

Regarding the demand side, not only the amount of APA only covers partly the services costs included in the care plan, with also important geographical differences. But the latter falls short of the real needs, leaving the beneficiary as seen above to cover the full costs of care when he can, or social welfare to be mobilised at both, national and general council levels.

Also the current formula to transfer money from the central level to the local one (General councils: GC) in order to manage welfare program he has been given responsibility of by the state, has been designed at national level in such a way that it fall short from covering the needs. So, for example if GCs want to increase their care spending, as they will continue to receive the same funding amount from the state, in order to finance more services they will (due to regulations calling for a balanced budget) have either to levy more local taxes (and thus appeal to the tax which they cannot afford extensively for political reasons) or ask users for higher out of pocket contributions. In both cases, both stakeholders are trapped. This system (coined 'gearing') is being deliberately designed to keep national costs down. This issue is high on the political agenda (see on-going tension).

One of the main difficulties encountered when attempting to devise integrated care systems is that all stakeholders, be they provider or funding institutions, keep their own accounts and pursue their own financial goals. For this reason, they are not inclined to see the LTC sector globally, as a system for which they are responsible together jointly as a team. So cost containment strategies pursued by each actor in the LTC field often result in transfers of charges to other parties, without any real reduction of costs taking place. Providers involved in long-term care are practicing what is coined as "cost-shifting". This has been the case with the introduction of a Diagnosis Related Groups (DRG/GHM) funding system in hospitals which gave strong incentive to reduced the patients' length of stay to produce cost-savings for hospitals but at the expense of increased pressure over the other sectors involved in long term care with older people discharged much 'quicker but sicker' in other settings (rehabilitation hospitals, nursing homes, home) and resulting in the well known "revolving door phenomenon". This is more and more taking place in France as paying organisations according to activity is more and more foreseen but involves non cooperative policies.

Another indirect measure to control costs resulted from the development of financial incentives aiming to facilitate direct employ of home worker by lowering user's charges. But this came at the price of a lower control by the state of their training level and skills of the hired person and thus to quality problems (IGAS, 2010). It has also been shown also (Cour des Comptes, 2010) that the fiscal incentives

structure favour the wealthiest fraction of the population, widening social care inequalities and creating a socio economic gradient between care needs and what beneficiaries are able to buy in the formal market of care with their available financial resources.

4.4 Professional

Multi-disciplinary working is increasingly demanded and expected, both within hospitals, and between different care settings. Hospital-based home care, integrated care, extended hospital care, Team working etc. all implies new patterns of how to share task among workers, institutions and sectors. Disregarding the yet quoted financial barriers), this is a practical challenge to the various stakeholders' ability and willingness to cooperate; but also a threat for the power of well-established stakeholders. Various survey have evidenced that the inter-organisational structures and relationships are still underdeveloped, sporadic, cumbersome and time-consuming resulting in joint-working attempts often being characterised by a lack of consensus agreements, conflicts, prejudice and unfulfilled expectations (as shown by the assessment done by the social affair inspectorate (IGAS) of geriatric networks linking hospitals, the primary care health sector and the social sector

The Difficulties in team working between the health and the social sector is often explain by contrast between a 'medical model' (which emphasises on individual biological approach focusing on medical treatment (cure) with a 'social model' (more focused on bringing social, environmental and attitudinal changes with the aim of including people with social care needs in society). But there exist also a very significant fragmentation *within* both health and social care with a range of different health and social care professionals, each trained slightly differently and taught to value slightly different approaches and concepts. This difficulty is even enhanced by an excessive division of labour, which increases the number of interfaces to be managed. As an overall result, there can be genuine disagreements between different professionals about the best way of responding to a specific need (often re-enforced by a separate performance systems they are accountable to); regarding attitudes to taking or preventing risk; different views about the potential contribution and rights of the service user and/or his family, notwithstanding the negative impact of using different language/jargon. Some professionals may also fear that collaboration may be threatening for their professional status as their specific expertise and contribution may be downplayed in this new regimen. Finally and not withstanding these difficulties, attempts to promote more effective joint working have tend to focus more on overarching technocratic organisational structures which neglect or forget the necessary prerequisites to develop joint training and organisational reengineering before people working in different organisational and professional cultures are able to work together.

4.5 Issues of status and legitimacy

There is a strong divide in the way the health and social sector are considered by the French population. The legitimacy of the health system is strong: first, access to health services is perceived as being a universally and positive right based on strong values. Second, the health care system is seen as a dynamic sector, whose function in creating wealth is related (through productivity gains) to its high degree of integration into the economic system. Also doctors in term of status are still highly valued in the hierarchy of professionals. Even the fact that the NPSF director is appointed by the government and not elected and that he benefits of a five year period during which he is in an almost "untouchable

position” has not really been considered as the stigma of a “democratic deficit” but more as the price to pay for more efficiency.

On the opposite, the social and welfare system, while far from being insignificant in economic terms, is viewed by decision-makers as an essentially non-productive sector relying on public funds. There exist still some ambiguities in the way users are considered: either as being a still active and somehow autonomous citizen or (as a majority thinks) as a “passive person” to be supported by publicly lead services. For even if social care is considered as having an important local democratic mandate with local government accountable to local voters and taxpayers, in the same time the LTC sector, because of the low technology and productivity of services is still considered under a “social approach” with services being delivered by a mass of poorly considered professionals and with a low value given to user’s voice either individually or collectively (see informal care report)

Finally, while health services are seen as belonging to a single system, social care services appear to be embedded in a more fragmented one as the LTC sector is not considered as being a real system”. CNSA designed at national level to be the coordinating institutional body of disability policies independently of age, and even if it integrate in its board all stakeholders has not the capacity and power to really impact on the set up of a coherent policy. This comes not only from its lack of financial resources but also because it has no steering power to rebalance the “medically driven” management of LTC services provision lead by the national public health agency as continue to pay more than 2/3 of the LTC services.

5 Key enablers to joint working

5.1 Shared vision

Building a shared vision between the different organisations/stakeholders/sectors involved in LTC on what constitutes the best practice especially in regard to Governance and financing is a central issue.

The central political level will certainly continue to exert a strong influence as in particular it gear the debate regarding the agreed upon type of arrangement on how to secure the funding of services for the older population with long term care needs and the one which related on how to set the best balance of responsibilities between the different political levels and stakeholders.

Only the first issue has gained visibility in the present time as the political process of pension reform being achieved in the end of 2010 the issue of how to finance services for the disabled elderly population is high on the political agenda and will be one of the main topic of the coming (May 2012) presidential election (see on-going tension section). But solutions for social care problems will also come from solving issues such as:

- Optimising the mix of formally and informally delivered services;

- Setting the optimal balance regarding competition and cooperation between public and non profit private providers on one side and private for profit ones on the other;
- Creating more functional links between the health and the social sector;
- Making an efficient adaptation of user's accommodation and living environment while enhancing social integration and healthy ageing program.

So the question of building specific arrangements aligned with the local environment of older people is at stake. Regarding this issue, the role of the new regional health agency (ARS) as a potential enabler is at stake: it may be that, through its strategic council, it may facilitate a formal public debate involving local political levels (General councils, municipalities) – although no clear guidance exists in the law for such an approach – in order to build a shared vision of how LTC should be organised and regulated. However, one has to acknowledge that these new agencies will have to act within stringent financial and institutional constraint environment as they are strongly supervised by the ministries of health and finance with a focus on more prioritised topics such as costs control of hospitals and issue such as dealing with restriction in access to primary care professionals. So it remains to see whether they will be able to act in the quoted direction.

5.2 Clarity of roles and responsibilities

At professionals' level

Provider's tasks domains, scopes and responsibilities between health and social care professionals are strongly defined in legislation. So that in areas involving their efficient coordination and cooperation (as hospital discharge and home care continuity), it is often left to each type of providers to decide their vision alone as the respective responsibilities of social agencies and hospital staff are not formally included in legislations. Solutions today rely more on informal arrangements at ground level than on more team working procedures (COPA⁶ practice example is an attempt to solve this problem).

In this regard also as ARS have received by law the legal responsibility to plan, supervise and regulate the activity of acute and rehabilitation hospitals, to plan primary care professionals activities and nursing homes; and although home agencies regulation are still beyond their control and as they have limited power in the financing of nursing homes), they could help in shaping more formal arrangement and regulations in common areas by setting a series of regional frameworks to help clarify the respective roles and responsibilities of all involved professionals and organisations and set a number of joint targets to encourage more joint working.

At clients' level

More and more enhancing the role of self-management and self-determination of the elderly population by strengthening their voice and knowledge is becoming a central goal of many European LTC policies. For example, disease management programmes entail the redefinition of the relation of the patient/client towards the (health) care professionals not in a legislative manner but in practical terms. This involves specific training for both types of stakeholders. Also by diversifying care services, governments are trying to enable people to make real choices. As people want the care they need to be available and close to their home, particularly when long-term care is needed, providing enough local

⁶ <http://interlinks.euro.centre.org/model/example/CoordinatingCareForOlderPeopleCOPA>.

facilities is of paramount importance by giving people greater ability to choose which service they wish to use and in the same time giving incentives to all services to improve their performance and responsiveness. But this power gain may exist only if enough formal services with a minimum quality are available in order users can choose the one which fits best their needs. So if in theory, to be given more choice should help foster better services certain prerequisites must be fulfilled:

- First freedom of choice does not always entail equal benefit: It is easier for people, in good health, well-educated and independent to make choices than it is for the most vulnerable members of our society to do so. So the most vulnerable among the population perceive freedom of choice as biased since they are not always or no longer able to make choices. So making quality information widely available and understandable for all social classes is a prerequisite to enable people to make informed choices themselves. In France, even if many information are available either through professionals, care organisations and different type of media, they are not provided and organised in a way that can allow potential user's (whether the older people and/or his relatives) an easy access and a real understanding which would facilitate their choice (see quality report).
- Second, competition will allow enhanced choice to be an efficient only if it is driven by quality and not only by prices (or costs). So unless competition is not carefully regulated and quality fairly assessed, choices based on prices may lead to lower quality but also to more social health inequality. This is the case in France where financial incentives have been designed in such a way that competition among the various types of home care providers is biased and mostly based on prices rather than on quality; and because these financial incentives tend to be more used by the wealthiest part of the target population (CC, IGAS). So it is likely that cooperation and integration may bring higher added value, rather than competition.

5.3 Appropriate incentives and reward for team working and integrated services

A key barrier to date has been that most policy, budgets, incentives and rewards operate on a single agency basis that can hinder a genuinely multi-agency response to the needs of older people. As the rationale of incentives and rewards tends to operate within a single stakeholder, the divide of responsibilities between stakeholders means that benefits are not always accrued by those bearing the costs of the initiatives. This is illustrated by the given above example of hospital cost shifting with policies rewarding a stakeholder only on the basis of their own performance thus preventing them from prioritising integrated and cooperative working.

6 Financial sustainability

With an ageing population leading to rising care needs, the current system is widely perceived as financially unsustainable: In the next 20 years, the number of people aged over 60 in France is expected to rise from 12.5 million in 2000 (21% of the total population) to 14 million in 2010 (22.7%), to 17 million in 2020 (30%) and to 21.5 million in 2040 (34%). There will be more than 4 million people over 80 in 2020 (a rise of 80% from 2000) and expected to be 7 million in 2040.

As disability frequency grows with age, it is not surprising that since it was launched, the number of beneficiaries of APA grew quickly to reach almost 1.2 million in July 2010 (overwhelming the less optimistic scenarios of the beginning 2000) and with a cost amount of €5.3 billion (20% of the public LTC costs) with a 62%/38% divide between beneficiaries living at home and in care homes.

Research has shown consistently that it is not age per se which is the main cost driver: In France, the intensive use of medical technology has a much stronger impact (70% versus 10%) in escalating costs. So the answer to the question of LTC sustainability lies in the complex relationship between the relative costs of chronic morbidity, disability per se and aging. Other research revealed that beneficiaries of APA have an average life expectancy of 4 years. In accordance to the scenario of morbidity compression at the end of life, medical but also social services tend to concentrate in the last 6 months of life.

More cost savings could also follow from allowing more people to live at home. This raises the question of the role of informal carers and how they mix with professional carers. When setting up the French attendance scheme APA, one of its goal was explicitly to “provide a public financial help for the OP in order to cover the charges of needed professional services”. But also and even if more implicitly (see previous paragraph), it was also designed to allow some financial recognition of informal carers contribution especially within the family, in order to secure in their long range availability to care as it was expected that the former would be lower in the future. At the same time this allowance was thus looked as a cost containment tool.

However, as APA can also have a negative effect by withdrawing carers from the labour market thus lowering the capacity of informal carers to contribute, by their work on the labour market to the growth of the economy and thus to the funding long term care services, an optimal balance has to be set between these contradicting goals in order to achieve sustainable financing scheme.

7 Good practice

7.1 Examples at the governance level

The current government, after having been criticised for not responding at appropriate speed and level of commitment to the care needs of an ageing population has now recognised the urgency of acting. Some good practices exist concerning governance exist in the LTC sector even if they are more developed and focused on its health care part. But some particular aspects of the social sector can be highlighted and examples to be share with other systems:

- **At the governance level**, following the vote in June 2009 of the HPST law, some funding has been earmarked by the ARS to support projects which have sought to compensate shifts in provision between health care settings (e.g. from hospitals to primary care) and improve coordination and management regarding certain chronic diseases or improved discharge from hospitals. Also the agency steering committee is also entrusted to designing tender in order to finance projects aiming at improving care continuity and more integration of services.
- **CNSA** is involved in programs to insure more equity in financing local levels (see above and Naiditch/Com-Ruelle, 2009)
- **A support policy for Alzheimer's** informal carers (see Naiditch, 2009).

Due to what has been coined as “the Alzheimer epidemic” and since the beginning of the 2000, all government have recognised the informal career's burden their caring tasks entail and have moved towards more recognition of their role. Three successive plans have been set up with the goal of enhancing informal career's conditions allowing them with some financial recognition and rights to of social protection and with innovative respite care formulas (see practice example). Case managers for the more disabled are to be developed as well as specific multi entry point of services to integrate all care providers (see MAIA⁷ good practice example).

Prepaid vouchers to buy and control the use of APA

In order to facilitate the paper work of APA users, and lower transaction costs and achieve a better control the appropriate use of the benefits, general councils and providers have agree upon using partially prepaid vouchers as the dominant means to buy home and personal care services and linked to fiscal incentives and less social charges.

7.2 Embedding good practice at ground level

Since 1997, policy makers have used a range of different incentives, sanctions and legal frameworks to try to embed good practice in everyday practice. Disregarding the issue of the appropriate public funding level which should follow, the following goals should constantly be embedded in any social care experiments and/or policy in order to bring more efficiency:

- **Bringing in Trust:** which can be facilitated by the availability of well trained professionals delivering their services in a optimal way and according to user's will.

⁷ <http://interlinks.euro.centre.org/model/example/NationalPilotProjectMAIA>.

- **Giving more voice to users:** by giving them (at least) the opportunity to express dissatisfaction if not enabling them to have a say on how services delivery should be organised and on how they are run.
- **Boosting team working at the ground level** in order to encourage/compel with changes.

The following initiatives can be quoted as they are based on one of these goals:

- The creation of national agencies to identify and disseminate good practices in health care and social care. The first one to be set up in 1996 is named HAS (Health accreditation and is similar to the health NICE. It has gained recognition, influence and power even if its decisions have sometime been challenged by patient groups and/or by professionals. This recognition is not yet there regarding the corresponding agency for social care called ANESM (National Agency for assessing home and residential care) as it is still too young (2007 to have gain such authority to enforce compliance with good practice. This comes also from the fact that its role and responsibilities with other bodies regarding quality management is not clear enough (see Naiditch/Com-Ruelle, 2009).
- CNSA not only promotes professionalization of the worker forces (with the cooperation of work ministry agency ANSP). One of its core missions is to help dissemination of good practices through supporting innovative organizations and by boosting grounded experimentations. (see quality report). Also most of the LTC research programs are funded by CNSA jointly with other funding research agencies.
- More recently there has been an even stronger emphasis on what would be called in UK “strategic commissioning” by the General Councils. But the promotion of a real choice/competition approach via a series of quasi-market or through a tendering approach has some opponents because there are strong concerns that this direction might make collaboration across the whole system harder.

Regarding the last point, the strong focus in direct hiring and payments of home help and care workers in order to encourage people to take greater control of their own support through individualised forms of funding has led to questions about the real capacity of elderly to use this opportunity but also regarding quality problems related to workers qualification. In order to bring more quality and safety in this market, all concerned umbrella organisations are now engaged into a more regulatory approach with collective agreement allowing training and education programs and social rights for directly hired workers.

8 On-going tensions

From the above picture of the current financing and governance of long-term care, a number of tensions and policy changes are lurking that could reshape long-term care in France in the next future.

In spite of recent policy proposals to reform the long-term care sector (called in France medico-social), the underlying health and social care divide continues based on the assumption that it is still meaningful to distinguish between people who are sick and those who are frail or disabled. This distinction between

health and social care are deeply rooted in the legal framework, professional practices and in the “financing/planning silos approach” regarding both sectors. While local stakeholders are increasingly told to fight against this “misconception” of what constitutes the essence of the LTC system, they have not yet been given the necessary institutional means and management tools to overcome all the issues resulting from such a division. In particular financial incentives in the current system are far from being adequately aligned with desired outcomes. As an example, the national sickness fund has launched studies in order to know what type of services she is now reimbursing which does not relate specifically to illness but “only” to disability in order to estimate the “added costs of disability”. This shows that an integrated system for funding is not on the political agenda.

Another still pending issue is the goal to overcome the age disability barrier. This is what the February 2005 Law intent to do by using a new approach and an ethos based on universalism of rights for all disabled person allowing each them the right to claim for a individual targeted care plan based on their “life project”. But as the crisis has brought on more financial constraints, it may be impossible nowadays to set the service’s provision in both populations in order that all person would be equally compensated for equal needs for this would mean giving more money to the underfunded elderly population in regard to the “younger” handicap population.

At local level (general councils) very few executives have try or have succeeded in setting policies that sought to compel and/or encourage local providers of different status (public, private not for and for profit) to form effective partnerships. Some have tried to use their (“Tariff capacity power”) to set contracts with specific providers in order to favour quality. But as their purchasing power was too weak and/or quality indicator were missing and/or follow up was not possible, these initiatives rather resulted in competition based on prices. But also, difficulties come from the fact that money coming from the central government has not follow at equivalent rate the growing responsibilities given to the general councils in framing and regulating social care policies, So local political level are now in a very bad position regarding their financial balance and are asking for more funding from the central government as they cannot provide care in good conditions.

Also the provider level, the focus has been on changing and merging organisational structures rather than on developing more joined-up practice at ground level or training to learn how to work with different organizational and professional cultures (see MAIA good practice example);⁸ while it also shows that many resources have to be poor in order to incentive people to change their working practice). It remains to see how the new ARS regional bodies will be able to promote and help local authority, whether at general council or municipal level, in order to help them overcome some of the difficulties inherent in inter-agency working and also to disseminate good practice. For without this type of “innovative grounded process” there is a real danger that everyone waits for national or regional action rather than taking responsibilities for finding solutions.

As mentioned above, informal care plays an important role in the French long-term care system. Reliance on informal carers is a way to keep expenditure under control as the public APA allowance can be set at lower level while beneficiaries continue to receive care coming from their relatives and friends. But even if the question of “how to help the helper” is on the agenda, at least at rhetorical level, it

⁸ <http://interlinks.euro.centre.org/model/example/NationalPilotProjectMAIA>.

remains doubtful that measures focusing Alzheimer informal carers, albeit moving in the right direction, will address the overall issue of informal carers' support policy as they mostly aim at helping carers to provide care rather than failing to address the overall issue of a global policy which encompasses measures making care compatible with work and usual life (see Triantafillou, 2010). Also the migrant carers involvement in the LTC system linked primarily to demanding working conditions, low wages and poor social recognition of home workers is still lagging behind as it has not gained recognition in the public debate.

Frightening statistics about LTC financial sustainability have raised the issue of the funding of services for older people – with significant national policy development and consultation underway. The most recent report in June 2010 (Rosso Debord, 2010) raised a hot debate regarding how to fund LTC for older people. Potential measures involved a restriction to public entitlements in return for slightly more generous long-term care funding for the poor and/or with heavy needs and an enhanced role for either voluntary or compulsory private insurance either individually or through firms. This proposal led to strong critics in particular regarding potential access problems in coverage for the more deprived population (Elbaum, 2008; Ennuyer, 2009; Henrard, 2009).

In order to respond to critics (as LTC was to become an important topic of the present and next year campaign of the coming presidential election (May 2012), the government launched a “public debate” along side asking 4 expert groups to propose different scenarios. Main outputs of their work published in June 2011 are as follows: €9 billion are to be found in the coming 30 years (up to 2040) in order to adjust for disability natural growth (with an estimate of 50% up to 2040 which corresponds to a supplement of 600,000 disabled older people): noticing that the present level of APA covers only 70% of the real needs. This corresponds for each year to a financial supplement of 0.11-0.14% of GDP up to 2025 and of 0.33-0.39 for the 2026-2040 period (baby boomer impact).

The more probable scenario is to consolidate the actual system with a strong public core (as the private insurers were not really interested in being the major player and as the solution of long term care being considered as a fifth risk and to be financed a public LTC insurance was excluded). So the general idea is now to correct main deficits of the present system (mainly by better answering to the needs of the most disabled (GIR 1 and 2) older people by enhancing the APA ceiling for these groups) and/or by enhancing “housing contribution” by redirecting money coming from fiscal exemption of the wealthiest part of the population; but also by gaining efficiency through a better channelling of information and enhanced coordination of the care process; and by better publicly financing support measures for informal carers and more professional services. The needed extra funding could come from: more taxation for retirees and a fraction of inheritance tax for the general population; or from one more “solidarity day”. Older people could still complement this public funding by buying private insurance in a more regulated market as it is presently and with subsidies coming from the state.

The final arbitrage is supposed to be issued by the end of 2011.

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