
Case study

France

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Abstract

The French long-term care (LTC) sector is complex with multiple funders and care providers managed by different levels of government. While the statutory health insurance (SHI) system allows a unified and relatively good coverage of medical LTC needs, the type and funding of the personal and social LTC services vary depending on the local authority. This has resulted in large differences across French *départements* in prices of personal LTC services and out-of-pocket payments faced by the recipients. Prices and payment mechanisms used for funding providers vary also for medical and personal LTC services. Regardless, none of the payment mechanisms take into account the quality of service providers. Lack of information on actual costs and care quality of the LTC providers hinders the capacity for improving the quality and efficiency of care provision in the LTC sector.

This chapter provides an overview of the funding and price setting mechanisms used in the LTC sector today in France, with the objective of staging the mechanisms used and issues raised. It first presents the main providers involved in the LTC sector and the major institutions responsible for funding and managing LTC services. By analyzing price setting mechanisms for different providers, we aim to identify major issues and possible solutions for advancing LTC services in France and in other countries.

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Glossary

Abbreviation	French original (if applicable)	English translation/ description
ADL	-	Activities of daily living
AGGIR	Autonomie Gérontologie Groupes Iso Ressources	A reference tool to assess the level of dependency of elderly people
AIS	Acte Infirmier de Soins	Nursing care acts (hygiene and surveillance)
ALD	Affection de Longue Durée	Long-term and costly chronic conditions for which there is no cost-sharing
AMI	Acte médico-Infirmier	Medical Nursing Act
ANAP	Agence Nationale d'Appui à la Performance	National Agency to Support Performance Monitoring
ATIH	Agence Technique de l'Information sur l'Hospitalisation	Technical Agency for Hospital Information
APA	Allocation Personnalisée d'Autonomie	Personalized Autonomy Allowance: a cash-for-care scheme for personal care
ARS	Agence Régionale de Santé	Regional Health Agency
ASH	Aide Sociale à l'Hébergement	Social aid in the form of cash benefit for housing
CNAV	Caisse Nationale d'Assurance Vieillesse	National old-age insurance fund
CNSA	Caisse Nationale de Solidarité pour l'Autonomie	National Solidarity Fund for Autonomy
CPOM	Contrat Pluriannuel d'Objectifs et de Moyens	Multi-year funding contracts defining care objectives
DI	Démarche de soins Infirmiers	Nursing acts for preparing an individual nursing care plan
DRG	-	Diagnosis Related Groups
EHPAD	Etablissement d'hébergement pour personnes âgées dépendants	Residential nursing homes
EMSP	Equipes Mobiles de Soins Palliatifs	Mobile palliative care teams
ENC	Etude Nationale des Coûts	National cost study
FIR	Fonds d'Intervention Régional	Regional Investment Funds
GIR	Groupe Iso-Ressources	Iso-weighted resource groups defining the dependency score
GME	Groupes Médico-Economiques	Patient classification system used in skilled nursing facilities for adjusting payments; each group combines medical and nursing care needs
GMP	GIR Moyen Pondéré	Average GIR dependency score in residential nursing homes

Abbreviation	French original (if applicable)	English translation/ description
GMPS	GIR Moyen Pondéré Soins	Average GIR score weighted by healthcare needs (PMP)
HAH	Hospitalisation à domicile	Hospital at Home
IADL	-	Instrumental ADL
LISP	Lits Identifiés Soins Palliatifs	Dedicated palliative care beds in acute care hospitals
LTC		Long-term care
NGAP	Nomenclature Générale des Actes Professionnels	Nomenclature of professional acts reimbursed by the SHI
ONDAM	Objectif National de Dépenses d'Assurance Maladie	National Objective for Health Insurance Spending
PATHOS		Classification system used in residential nursing homes to assess care needs; there are 238 pathos based on 50 clinical profiles and 12 nursing care needs.
PMP	Pathos Moyen Pondéré	Average PATHOS score in residential nursing homes
SAAD	Service d'aide et d'accompagnement à domicile	Home-Care and Support Services
SPASAD	Services Polyvalents d'Aide et de Soins à Domicile	Multi-Purpose Services for Homecare
SSIAD	Services de soins infirmiers à domicile	Home-Care Nursing Services
SSR	Soins de suite et de réadaptation	Post-acute rehabilitation facilities
SHI		Statutory Health Insurance
USLD	Unité de soins de long durés	Long-term care departments in acute-care hospitals
USP	Unités de Soins Palliatifs	Palliative care unit in acute care hospitals

1

Introduction

The long-term care (LTC) policy in France cuts across different sectors including health, medico-social and social and involves different levels of governance. By definition, LTC involves a variety of services, provided in different places by different caregivers, to help people live as independently and safely as possible when they can no longer perform everyday activities on their own (NIH 2017). In order to analyze the organization and funding of LTC services, it is useful to distinguish the three main categories of services as defined in health accounts (OECD 2018):

- **Medical and nursing LTC** services include wound dressing, administering medication, health counselling, palliative care, pain relief, diagnosis and treatment with relation to a long-term condition. They can also include preventive activities to avoid deterioration in long-term health conditions or rehabilitative activities to improve functionality (e.g., physical exercise).
- **Personal LTC** services provide help with activities of daily living (ADL) such as eating (support with food intake), bathing, washing, dressing, getting in and out of bed, getting to and from the toilet and managing incontinence.
- **Social LTC** consists of assistance services that enable a person to live independently. It relates to help with instrumental (I)ADL such as shopping, laundry, cooking, performing housework, managing finances, etc.

In France, the government defines national health and social care policies, while the funding for LTC comes from a mixture of sources including social security contributions and local taxes. The statutory health insurance (SHI) fund covers **medical LTC services** for all the population. The system guarantees universal access to a large basket of health care but imposes significant co-payments for all services including primary and LTC. Co-payments for medical LTC are largely alleviated by a specific exemption scheme, *Affection Longue Durée* (ALD), created right at the inception of SHI in 1945, which aims to reduce the financial burden of medical care for beneficiaries suffering from long-term and costly chronic conditions. Irrespective of their income status, these patients are exempted from co-payments (*tickets modérateurs*) concerning treatments associated with a list of conditions including cancer, mental illness, dementia, etc. Medical LTC policies are implemented at the local level by de-concentrated State services: Regional Health Agencies (*Agence régionale de santé*, ARS). The missions of the ARS include regulating the care supply (managing the authorizations for opening health or residential care facilities, number of places, etc.), monitoring and regulating the volume and quality of services and negotiating the medical portion of the funding for residential nursing homes.

The key policy for covering **personal and social LTC services** developed in the late 1990s is based on a cash-for-care scheme, initially called “Specific Allowance for Dependency” concentrating on persons with very high care needs (Le Bihan and Martin 2018). The scheme was reformed in 2002 and became the personal allowance for autonomy (*Allocation personnalisée d'autonomie* - **APA**), providing benefits to meet personal care and assistance needs which are not covered by SHI. APA is a needs- and means-tested allocation for elderly people which can be received at home or in residential care homes. It is funded both by national contributions and local taxes and managed locally by the local authorities *départements*. The *départements* are the level of government below the national level in France. There are 95 departments in metropolitan France, each administered by an elected body, called a departmental council, with tax raising powers. Their main areas of responsibility include the management of welfare allowances, social and medico-social action¹. The 2014 law of modernization of the territorial public action strengthened the role of the departments as “leaders” in social and LTC policy. This decentralization means that the level of funding for personal and social LTC varies across *départements* depending on their wealth (resources) and policy priorities.

In order to improve the equity in funding of LTC across regions, financing mechanisms and the rules for reallocating public finances have been gradually reformed since 2002. In 2004, the National Solidarity Fund for Autonomy (*Caisse nationale de solidarité pour l'autonomie*, CNSA) was created to finance a common LTC policy for older and disabled people. Today, a part of LTC funding is provided via a national formula that takes into account the patient case-mix in LTC institutions and local care needs. In the past 10 years, the LTC sector has also undergone an organizational reform, which has led to a significant decrease in the number of LTC beds in hospitals, with a desire to favor care as much as possible in people’s own household and to shift LTC beds to medical nursing homes. However, the recent public health crisis due to Covid-19 pandemic raised questions about the adequacy of funding for LTC in nursing homes and at home.

This chapter provides an overview of the funding and price setting mechanisms used in the LTC sector today in France, with the objective of staging the mechanisms used and issues raised. We start with a presentation of the main providers involved in the LTC sector, followed by a review of the major institutions responsible for funding and managing LTC services. By analyzing price setting mechanisms for different providers, we aim to identify major issues and possible solutions for advancing LTC services in France and in other countries.

1 Along with managing junior high schools, local roads and infrastructures, etc. (<https://www.vie-publique.fr/fiches/les-departements>)

Medical and personal LTC services are mainly provided in skilled nursing facilities, in residential nursing homes or at home.

2.1 Skilled nursing facilities

Skilled nursing facilities in France (called “post-acute and rehabilitation services”, *Soins de suites et de réadaptation, SSR*) provide short term rehabilitation, patient education and medical support services usually after a hospitalization. They provide assistance with healthcare and ADL, but can also perform palliative care, preventive actions to reinforce mobility of the elderly patients, educate patients to self-manage their conditions, etc. Typically, they would have both inpatient and outpatient services. In 2017, there were 1646 skilled nursing facilities in France, 43% of which were in the public sector, about a third in the private non-profit sector and a third in the private for-profit sector (Table 1). About 1 million patients were treated in skilled nursing facilities in 2017 (ATIH 2018). Of these, nearly 65% were over the age of 70. The average length of stay in inpatient skilled nursing facilities was 35 days, and three quarters of the admissions were after an acute hospitalization.

Skill nursing facilities mostly support people who need short term assistance with medical and personal LTC (musculoskeletal, neurological and cardiovascular diseases, post-surgery, etc.), but they can also play an important role in the provision of LTC for people with severe mental or cognitive problems, especially older people with dementia or Alzheimer’s disease when it is difficult to manage them at home or in residential care facilities.

2.2. Residential care facilities

There are two types of residential care facilities for older persons: those which provide medical care with personal and social care, and those that provide only personal and social care.

2.2.1 Medical residential facilities

Medical residential care facilities take care of complex elderly persons who need medical attention, as well as personal and social LTC services. For elderly persons who need long-term medical care, there are two options of residential care: residential nursing homes or hospital LTC departments.

Residential nursing homes (*Etablissements d’hébergements pour personnes âgées dépendants, EHPAD*) give shelter to older persons (over 60 years old) who need regular care and medical surveillance as well as assistance to perform ADL. This is the most common form of residential care for older persons in

France, with around 600 000 places in 2018 without counting day-care places (Statiss Database 2018). Almost 10% of people over age 75, and one in three people over the age of 90 live in residential nursing homes in France (Muller 2017a). Care providers in nursing homes are mostly paramedical staff (certified nursing assistants and practicing nurses), working usually with a part-time physician and sometimes with a psychologist. In 2017, there were 6992 residential nursing homes in France (Moreau and Toupin 2019), of which 42% were public, 32% were private-non-profit and 26% were private-for-profit (Table 1). The average age of elderly people living in nursing homes is 86 years old, and the average length of stay is about 2 years and 5 months (Muller 2017a). Around 70% of residents of nursing homes live there until the end of their lives. Nursing homes play an important role in palliative care in France. In 2015, about 75% of residents of nursing homes died in their residence and 25% in hospital (Muller and Roy 2018). In order to avoid hospitalizations and improve the quality of care at the end of life, nursing homes have been investing in palliative care skills and collaborations with mobile palliative teams in recent years.

LTC departments in hospitals (*Unité de soins de longue durée, USLD*) function like nursing homes in a hospital setting. The number of USLD beds went down significantly in the past 15 years. The LTC policy aimed to shift elderly patients needing medical LTC to residential nursing homes. Between 2001 and 2015, the number of hospital LTC beds was reduced from 84 000 to 32 000 (Statiss Database). The average age in USLD is 84 years old, and the average length of stay is around one year and 7 months (Table 1). Eighty percent of USLD patients die in the hospital (Muller 2017a). Generally, people in USLD have a more degraded state of health than people in nursing homes (Delatre and Paul 2016).

2.2.2 Non-medical residential care facilities

These facilities provide only personal and/or social services. The most common facilities are **social residences** (*residences autonomie*), which are regulated and partly funded by the *départements*. These are residential facilities where older people live in their own apartments and share common amenities. Elderly people who live in these are relatively independent to perform their own personal care, but they would need help with so called instrumental (I)ADL such as laundry, meals, social and recreational activities. Social residences can be partly funded by local authorities as part of their LTC policy. There were around 100 000 older persons who lived in 2267 publically funded social residence in 2015 (Leroux et al. 2018). About two third of the facilities under contract with local authorities were in the public sector, 28% in the private non-profit sector and only 4% in the private for-profit sector.

In addition, there are private “**care homes**”, which are not regulated by the local authorities. In 2017, there were about

620 residences and roughly around 50 000 apartments (Mure 2018). Nevertheless, the private “care home” sector has been booming in recent years: between 2013 and 2017, there were 170 new private residences, representing a growth rate of 40% over that period.

2.3. LTC services at home

According to the CARE survey, in 2015, between 4% and 10% of people aged 60 or over who lived at home needed some help with their ADL (Brunel and Carrère 2017). LTC services at home range from hospitalization at home to nursing aid and domestic help provided by many providers. Different providers are financed from different sources and target different patient populations.

Hospital at home (hospitalization à domicile, **HAH**) is defined as “a service that provides treatment by health care professionals in the patient’s home for a condition that otherwise would require acute hospital in patient care” (Shepperd and Liffe 2005). In 2018, almost 122 000 patients were hospitalized at home for 45 days on average (ATIH 2018). Half of the patients treated were over 65 years old, a constant rate for several years, which represents 63% of HAH days. HAH is also increasingly used in residential nursing homes in order to avoid hospitalizations, especially at the end of life. By demanding to put in place a HAH protocol, nursing homes can provide palliative treatments that require material and medical services that are not normally available. In France, certain medications which are allowed for easing pain at the end of life can only be prescribed in hospitals or in an HAH. The HAH in nursing homes keeps elderly persons and their families in a familiar environment during the end-of-life and may improve palliative care quality.

Self-employed healthcare professionals: Mainly self-employed independent nurses provide most of the medical and personal care at home. While they are supposed to perform mainly medical nursing care, they also provide a considerable amount of personal care. In 2018, there were 124 000 self-employed nurses in France. While there is no specific information on the case-mix of patients of self-employed nurses, more than 60% of spending for these nurses concerns diseases mostly prevalent in elderly people such as heart failure, neurological or degenerative diseases (Cour des Comptes 2018). Another key profession which provides LTC in the community is physiotherapists. They can provide services both at home and at community centres. The expenditure on self-employed nurses and physiotherapists has been increasing very rapidly, with an average annual growth rate of 5.7% between 2000 and 2015 (Cours des Comptes 2015).

There are also two formal structures specialized in providing LTC services to elderly people at home. **Home-care nursing services** (*Services de soins infirmiers à domicile*, SSIAD) are mostly non-profit associations or public organizations, whose

vocation is to provide nursing care for older people (over 60 years old). On medical prescription, they perform nursing services in the form of technical procedures (injections, bandages, preparation of drugs, etc.) and basic hygiene and comfort care. There were 124 000 home-care nursing places in 2018 (Statiss Database 2018). The average age of patients using SSIAD was 82 years old in 2008², and on average patients received nursing care at home for two years and three months (Chevreul et al. 2009).

Home-care and support services (*Service d'aide et d'accompagnement à domicile, SAAD*) are private or public organizations, authorized and regulated by local authorities, that provide personal and social care services, helping both with ADL and IADL such as home support, maintenance and promotion of physical and social activities for the elderly. There are about 6000 SAAD representing 75% of the domestic help supply in France (Libault 2019). Most of them are private non-profit organizations (60%), with only 11% public and 29% private-for-profit services.

Services provided by SSIAD, SAAD and independent nurses are not always well articulated, and often an elderly person receive services from many different providers who do not communicate well. Therefore, there were some efforts to bring together services provided by SSIAD (nursing) and SAAD (personal care) under the same structure called SPASAD (*Services Polyvalents d'Aide et de Soins à Domicile*), which are multipurpose services for homecare. Nevertheless, while they were launched more than 10 years ago with the objective of integrating LTC services for the elderly, SPASAD have not effectively developed until now. In 2017, there were less than 100 integrated (SPASAD) services in France (FEHAP 2017).

Self-employed domestic help

Elderly people can also employ directly a more or less qualified professional for LTC services at home, except for medical LTC. There is a public system which allows to declare in a simplified way the employment and remuneration of domestic help at home and to receive tax reductions (50% of the total salary, with an upper limit). This measure, which is not specific to elderly care, can be used for any domestic help and aims to increase formal employment in this sector.

2.4 Palliative care

In France, there are three main palliative care providers. First, acute care hospitals play a major role in palliative care with dedicated beds for palliative care in different departments (*Lits Identifiés en Soins Palliatifs*, LISP) as well as palliative care units (*Unités de Soins Palliatifs*, USP)³. Second, HAH (see above) is proposed as an alternative for palliative care at the home setting and increasingly in residential nursing facilities. Finally, there are mobile palliative care teams (*équipes mobiles de soins*

² These are the latest and only available statistics.

³ In 2018, there were 5479 palliative care beds in various hospital departments and 1776 beds in 147 palliative care units (Bohic et al. 2019).

palliatifs, EMSP), which assist and train healthcare providers involved in end of life care either in hospital or in other settings. These are multi-professional teams, usually involving physicians and nurses, and part time psychologists and physiotherapists, attached to a hospital, often a palliative care unit. Different from HAH, these teams do not provide palliative care, but they play an advisory and support role assisting both healthcare professionals involved (training for palliative approach in or out of hospital) and families (psychological or social support for caregivers). In 2015, there were 425 EMSP with, on average, 3.6 professionals⁴ (Bohic et al. 2019). These teams can also assist with end-of-life care at home or in residential nursing homes. In 2015, 26% of the interventions by palliative care teams were at home, and 21% in residential nursing homes.

Table 1
Description of major LTC providers and their users, 2018 or latest year available

	Providers				Users		
	Number of facilities	Public	Private non-profit	Private for-profit	Number of users (person)	Mean age	Mean length of stay
Skilled nursing facilities	1600	43%	28%	29%	1 million	70	35 days for inpatients

Residential care facilities

Residential nursing homes	7000	42%	32%	26%	600 000	86*	2 years and 5 months
LTC departments in hospitals	600	n / a	n / a	n / a	32 000	84*	1 year and 7 months
Social residences	2200	68%	28%	4%	100 000	81*	5 years and 1 month
Private care homes	600	0%	0%	100%	55 000 apartments	n / a	n / a

LTC services at home

Hospital at home (HAH)	300	42%	41%	17%	122 000	63	42 days for women; 49 days for men
Self-employed nurses	124 000	0%	0%	100%	n/a	n/a	n/a
Home-care nursing services (SSIAD)	2100	36%**	63%**	1%**	124 000	82**	2 years and 3 months**
Home-care and support services (SAAD)	6000	11%	60%	29%	n / a	n / a	n / a

*Mean age when they arrived in the facility;

** Most recent data is from 2008.

Sources: ATIH (2018); Chevreul et al. (2009); Leroux et al. (2018); Libault (2019); Moreau and Toupin (2019); Muller (2017a); Mure (2018); STATISS database (2018).

4 Full time equivalent (FTE)

3 Funding and management

The funding and management of LTC services in France involve several levels of governance and different institutional actors which are not always well coordinated. Medical LTC services are essentially financed by the SHI, while personal and social care is financed by the local authorities (*départements*) and by the State jointly. Regional and local administrations implement funding, following the rules set at the national level, and monitor LTC provision, while decentralized local authorities have a large autonomy in provision and funding of personal and social care services.

3.1 Financing medical LTC

The main mechanism for defining and monitoring health and LTC budgets for SHI is macro-level expenditure targets, known as the National Objective for Health Insurance Spending (*Objectif National de Dépenses d'Assurance Maladie, ONDAM*). This involves setting an *a priori* global budget for health each year. ONDAM targets are set in monetary terms by the government for the forthcoming calendar year and give all stakeholders a precise objective in terms of spending. The overall ONDAM target is split into three sub targets for the main health service providers: outpatient, inpatient and medico-social services (Table 2).

Different LTC providers are funded from different ONDAM budgets. The spending for self-employed LTC providers in the community or working with older people at home, such as nurses and physiotherapists, are covered in outpatient budget in ONDAM. In 2017, the total expenditure for self-employed nurses represented 4% of total SHI spending (Table 2). The payments for skilled nursing facilities⁵, HAH, palliative care in hospital and hospital LTC departments come from the inpatient budget, while residential nursing homes and home nursing services are in the medico-social budget, ONDAM's medico-social budget is distributed to regional health agencies by the CNSA mostly on the basis of past expenditures. In 2017, the total expenditure for LTC services was about €20 billion and represented 10% of the total SHI budget (Table 2). The SHI budget for medico-social care is further divided into two separate services for elderly people over the age of 60 and LTC services for people with disabilities under 60 years old. Indeed, in France LTC policy, benefits offered and providers vary sharply before and after 60 years old. In this paper, we focus on the LTC policy for elderly people (60+ years). SHI spending for medical LTC services for the elderly covered residential nursing homes and home-care nursing services and represented about 5% of ONDAM.

5 With €79 billion in 2017, these facilities represented 41% of total inpatient spending.

In August 2020, following the high death tolls in nursing homes due to coronavirus disease and the discussions on adequacy of funding for LTC, the government decided to create a new (5th) branch of social security for LTC funding (L.200-2 of the CSS). LTC spending which were previously part of the SHI budget and financed by ONDAM will be covered now by a new branch, called "autonomy" which will be managed by the CNSA. It will receive a share of tax funding from generalized social contribution (CSG) to finance the LTC services covered by health insurance before. The objective in the medium term is to increase significantly the budget and scope of services covered by the CNSA with transfers from other social funds (Vachet et al. 2020).

LTC services can also receive funding from the Regional Investments Funds (FIR) which are used for financing regional or local initiatives (often in the form of experimentation), aiming to improve the quality and efficiency of care provision, care coordination and safety. For example, the mobile palliative teams which play a role in improving care coordination at the end of life are funded from this envelop (about €150 million in 2018; FIR 2019).

Table 2
Distribution of statutory health insurance spending in France, 2017 (ONDAM)

	Spending (million euros)	Share of ONDAM
1. Total outpatient spending	87 174	45.7%
Self-employed nurses	7536	4.0%
Self-employed physiotherapist	3998	2.1%
2. Total inpatient spending (acute care, SSR, psychiatry, USLD)	78 612	41.2%
Skilled nursing facilities (only public and private non-profit sector)	14 716	7.7%
Hospital at home (HAH)	1000	0.5%
Hospital long-term-care departments (USLD)	1004	0.5%
3. Medical LTC services	20 000	10.5%
For elderly people (residential nursing homes, nursing and social services at home)	9050	4.7%
For people with disabilities (less than 60 years old)	10 950	5.7%
4. Regional investment funds (FIR)	3240	1.7%
5. Other	1658	0.9%
Total ONDAM	190 683	100.0%

Source: Cour des comptes (2018).

3.1.1 Long-term illness exemption scheme

The public health insurance in France covers 100 percent of the resident population and provides a comprehensive basket of care but requires cost sharing for all services, including doctor and nurse visits and hospitalizations. Therefore, a long-term illness exemption scheme, called *Affection Longue Durée* (ALD), was created at the inception of SHI in 1945, with the objective of reducing the financial burden of medical care for beneficiaries suffering from a list of long-term and costly chronic conditions. Initially introduced to cover four groups of diseases (cancer, tuberculosis, poliomyelitis, mental illness), the scheme was extended over time and now covers thirty-two groups of diseases. Irrespective of their income status, patients are exempted from the co-payments concerning treatments associated with these conditions. Nevertheless, they still have to pay any fees linked to extra-billings and deductibles and the co-payments concerning other health problems. In 2016, over ten million individuals were covered by the ALD scheme, representing about 17 percent of SHI beneficiaries and accounting for roughly 60 percent of health expenditures reimbursed by the SHI (Sécurité sociale 2019).

Self-employed nurses and physiotherapists, who play a central role in medical and personal LTC services at home, are directly funded by the SHI. For the general population, SHI reimburses 60% of the cost of nursing services (on the basis of negotiated prices). For people covered in the ALD scheme, the full cost of nursing related to the condition concerned is reimbursed.

3.1.2 The role of CNSA

The CNSA, introduced by the 2004 law on solidarity and loss of autonomy, is a national institution responsible for funding and implementing policies for the elderly and people with disabilities to guarantee equal treatment across the country. The CNSA had its own finances, amounting to €5 billion in 2018, mostly from the “solidarity day”, a social contribution created by introducing an unpaid working day in 2006 and some other taxes. Until the creation of the autonomy branch in August 2020, SHI had transferred ONDAM budget to CNSA (€20 billion in 2018) to finance medical LTC services for the elderly and for people with disabilities. The CNSA distributed these funds (plus €1.3 billion from its own resources) to ARS that fund medical LTC producers (residential nursing homes and home-care nursing services, SSIAD). In 2018, CNSA also distributed €3.2 billion of financial assistance to local authorities, of which 2.3 billion were used to fund APA. Overall, 40% of total APA funds comes from the CNSA (CNSA 2019). These funds are redistributed to local authorities using a national formula based on four criteria: the number of elderly people aged over 75 years in the area (50% of endowment criteria); past expenditure on APA in the local authority (20%); tax potential in the *département* (25%); the number of low-income elderly (65+) people (5%). CNSA also financially supports local authorities to fund social residences (€40 million

in 2018). With the creation of a dedicated branch to autonomy, CNSA will have more resources and responsibility in funding medical LTC.

3.1.3 The role of ARS

Medical LTC providers in residential nursing homes and at home are paid through ARS. The ARS are deconcentrated government agencies⁶, created in 2009, with the mission of managing health and social care services and health promotion actions. ARS are responsible for monitoring, financing and regulating health and LTC services at the regional level.

They finance residential nursing homes and home-care nursing services on the basis of multi-year funding contracts (*contrat pluriannuel d'objectifs et de moyens*, CPOM). These contracts are the major tools for the ARS to regulate the number of residential LTC places and the level of nursing resources. They fund basically the cost of medical care (nursing mostly) in residential nursing homes ("health care package" as explained below). In 2017, funding from the ARS represented on average 30% of the revenues in nursing homes (Moreau, El Amaroui and Toupin 2017). The cost of home-care nursing services (SSIAD) are totally funded by the ARS without any co-payment from the users. This is the only healthcare service in the French system, except the emergency department in hospitals, which is accessible without any co-payment.

The LTC budget that is available to each ARS is defined by the CNSA by using a "regional care allocation" formula. This is mainly based on past expenditures adjusted by the inflation, targeted number of new places (in nursing homes and SSIAD) and targeted payments to achieve the objectives set in ONDAM.

3.2 Funding of personal care and assistance services

The politics of medico-social care is under the responsibility of local authorities (*département*) which are decentralized bodies in France. The « *département* » is directed by a council elected by universal suffrage for six years. There are 95 « *départements* » in metropolitan France, with 800 000 inhabitants on average⁷ (Insee 2020). Concerning personal care and social care services for elderly people, the *départements* have the legal authority and the obligation to define their local policy orientation, finance social care and regulate services. Home-care nursing services (SSIAD) and self-employed nurses are the exceptions, where providers are only funded by the SHI.

The main funding source for personal and social LTC services is the national allowance program (*Allocation personnalisée d'autonomie*, APA). This is a cash-for-care scheme which is

6 Deconcentration is considered to be the weakest form of decentralization (Rondinelli, Nellis and Cheema 1983). It consists of a delegation of power to lower territorial levels within central governments and central agencies. The central government always decides on local affairs but decides locally via its services located on the territory (Polton 2004).

7 The median population of a department is about 500 000 inhabitants, but this varies from less than 80 000 inhabitants in Lozère to 2.5 million in the Nord (Insee 2020).

managed and, mostly, financed by the local authorities. APA is paid to any person aged 60 or over who needs assistance to accomplish everyday activities or needs to be continuously surveyed. The allowance can be received at home or in residential institution, and the amount depends on the level of dependency measured by a national scale.

In 2015, 1.3 million, or 8% of the people over 60 years old benefited from this program; about 500 000 of whom were in a residential nursing homes (Leroux et al. 2017). About 60% of APA is funded by local authorities through local taxes, while 40% comes from the CNSA (CNSA 2019). In 2015, total spending for APA was €5.6 billion (3.3 billion of which for home services), with an average spending per person of €4450 per year (Leroux et al. 2017). The amount of APA at home and in residential care facilities are set via two different financial mechanisms, with different price setting rules, as we present below.

3.2.1 APA at home

APA eligibility is defined by the *département* using a national assessment tool measuring dependency. The dependency score (*groupes iso-ressources*, GIR) is calculated using 10 variables of physical and mental activity (coherence, orientation, capacity of going to toilet, dressing, eating, continence management, getting out of bed and lying down, moving inside the home, moving outside, being alert⁸) and seven variables of domestic and social activity (cooking, household duties, using transport, shopping, managing finances, managing medications, having external activity⁹). There are six dependency levels, 1 being the highest level of dependency (needing continuous attention) and 6 self-sufficient (needing no help). Those in the first four levels of dependency are eligible for APA. Allowance is paid to finance a specific “care plan” at home elaborated by an interdisciplinary team (usually consisting of social assistants and nurses)” of the *département* after an assessment. The “care plan” defines the number of hours of personal and/or social care needed as well as needs for day-care and other living adjustments for maintaining the person in the community. Each level of dependency allows funding a maximum amount (for funding the care plan) set at the national level. Therefore, both the eligibility to APA and the amount to be paid (care need) are defined by the local authorities who are the main funders. This differs for younger people (under 60 years old) with disabilities, for whom an independent agency assesses the level of dependency and makes the decision for the eligibility and level of LTC funding for each person.

On January 2019, the maximum amounts paid for APA varied from €672 per month for level 4 (low dependency: help with washing and dressing, body care and meals) to €1737 per month in level 1 (high dependency: continuous surveillance).

8 Capacity to use a means of remote communication: telephone, alarm, doorbell, remote alarm, etc.

9 Practicing voluntarily, alone or in a group, various activities that create events breaking the monotony of everyday life.

The amount of the allowance is adjusted by the income of the recipients. For people with a monthly income below €800, 100% of the care plan is paid by the local authority. The rate of co-payments increases with income up to 90% for those with a monthly income of over €2948. On average, APA pays for around 80% of the care plan cost. In 2017, the average APA amount paid at home was €450 per month (varying from €293 for level 4 to €1072 for level 1) (Arnault 2019).

3.2.2 APA in nursing homes

In residential nursing homes, APA finances “the dependency bundle” covering the cost of personal and social services to help with ADL (c.f. section 5.2). The “dependency” bundle represents on average about 15% of nursing home revenues (Moreau, El Amaroui and Toupin 2017). The eligibility rule is the same at home and in nursing homes: people on the first four levels of the dependency score (GIR) are eligible. On average, about two-thirds of the cost of dependency bundle is covered by APA and a third by out-of-pocket payments. However, cost-sharing arrangements vary across *départements*. Some departments increase the cost sharing depending on the income of residents while others do not; some finance the nursing homes with global budget while others finance, as at home, directly the person who then pays the nursing home. The ARS partly monitors this policy, as they sign multi-year contracts defining care objectives and resources (CPOM) with local authorities.

Table 3
Personalized autonomy allowance (APA) to fund LTC services at home

Funding sources	About 60% of APA is funded by decentralized local authorities (<i>département</i>) via local taxes, while 40% comes from the CNSA
Eligibility criteria defined nationally	Over 60 years old Mid-to high dependency: the first four levels on the national dependency score (GIR) based on 10 variables of physical and mental activity and seven variables of domestic and social activity
Evaluation of a “care plan” by local authorities	Multidisciplinary teams of local authorities evaluate the GIR and define a “care plan” (medical and social)
Amount of the allowance: National rules	Maximum amount for the “care plan” by dependency level : – €674 per month in level 4 (low dependency) – €1011 per month in level 3 – €1399 per month in level 2 – €1742 per month in level 1 (highest level of dependency) Co-payment: depending on income. On average 20% of “care plan”. Under €800 recipients do not have any co-payment, over €2900 contribute to 90% of the cost.
Definition of “care plan” amount	For each type of LTC provider at home (SAAD, self-employed domestic help, days-care), local authorities fix the reference prices. These prices are used by the interdisciplinary teams to calculate a “care plan” amount (number of days or hours multiplied by the reference price). Reference prices vary significantly across local authorities.

3.2.3 Others social cash benefits for LTC

Local authorities can also provide some other specific cash benefits to subsidize the **cost of housing** in residential nursing homes and in social services, called “social assistance for accommodation” (*Aide sociale à l’hébergement*, ASH), to help people with low income. The cost of accommodations in nursing homes represents around 50% of the total nursing home cost (Moreau, El Amaroui and Toupin 2017). The amount of allowance for accommodation is defined by the local authorities and consider the income of the resident (if it is lower than the accommodation fee), but, in the majority of cases, children and sometimes grandchildren have the obligation to cover the accommodation fees if the older person does not have the resources. The sums paid by the local authorities for accommodation are recoverable from the assets of the elderly person (if there is any) or if the financial situation of the person improves. Local authorities control the accommodation fees (prices) in nursing homes, which have places eligible for social assistance, and in social residences (part 5.1). In about two thirds of nursing homes, all of the places are eligible for social assistance, while in 17% a few places are eligible but not all (Muller 2017b).

3.3 Pension funds

Pension funds can offer financial assistance to retired people who need homecare but who are not eligible for APA because they do not have a high level of dependency for carrying out daily activities (GIR 5 and 6). The pension funds set the eligibility rules, often on the basis of household income. The “national old-age insurance fund” (*Caisse nationale d’assurance vieillesse*, CNAV), which is the main pension fund in France, spent €341 million in 2018 for 332 400 people benefiting from individual assistance for home support (CNAV 2019).

3.4 Central government tax benefits

In 2014, the central government funded around €2.4 billion for LTC (Libault 2019). There are two specific tax benefits that concern LTC at home and one in residential nursing homes. The first one is not specific for elderly LTC but plays a major role in funding personal and social LTC at home. This is a global tax benefit policy in France to encourage the legal employment of domestic staff at home (help for elderly, childcare, housekeeping, etc.). About 50% of the cost of domestic staff is recuperated by the employer as tax return (with a limit of €7500 per year¹⁰). Secondly, the beneficiaries of APA and people over 70 years old do not have to pay employers’ social insurance contributions. Finally, older people can also benefit from a tax reduction in residential nursing homes if they have taxable income over their accommodation fee¹¹.

¹⁰ For people over 65 years old (the tax return maximum is €6000 before 65 years old).

¹¹ A maximum of €2500 as a tax reduction per year.

3.5 Out-of-pocket payments

Concerning personal and social LTC needs, the out-of-pocket payments at home after APA and tax benefits is relatively reasonable and fairly well distributed according to income, while the out-of-pocket payments in nursing homes can be quite high (Libault 2019). At home, the average out-of-pocket payment is estimated to be around €60/month (varying from zero for incomes less than €810/month to €320 or more for incomes higher than €3600/month). However, in nursing homes, the average, out-of-pocket payment is around €1850/month, which exceeds older person's incomes in 75% of cases. About one person in five in nursing homes benefits from social subsidies for paying their accommodation fee, and many others are supported financially by their families. There is a specific LTC insurance to cover personal and social care needs, but most of the contracts do not cover high LTC risk. There are around 2 million people who own LTC insurance with coverage until death. In 2016, €246 million were paid by private insurance funds, while the total household out-of-pocket payment is estimated to amount €10 billion (Bennet and Fontaine 2017).

For medical LTC needs, on the other hand, the co-payment exemptions for the chronically ill (see part 3.1) reduce significantly the out-of-pocket payments of older people (Penneau, Pichetti and Espagnacq 2018). In general, the out-of-pocket payments for medical LTC (co-payments) are well covered by complementary private insurances. Given that 95% of the population owns complementary private insurance, inequalities in out-of-pocket payments are mainly linked to the costs of complementary health insurance, for which the premiums increase with age.

4

Base for payment

Most medical LTC providers are self-employed and paid by fee-for-services on the basis of a prescription from a general practitioner. Skilled nursing facilities, residential nursing homes and homecare nursing services are funded by global budgets. Historically, all these budgets were based on past expenditures or patient volume. In the past 10 years, most of the payment schemes have been adjusted slowly in order to take into account the characteristics of the care recipients (case-mix).

Personal and social LTC services are provided by a mixture of salaried personnel working in nursing homes or homecare service platforms, and self-employed helpers, often without much qualification. Local authorities distribute funds using mainly APA cash-for-care benefits paid to the care users and global budgets.

5 Price setting

Price setting for LTC services is complex and often poorly documented especially in the social care sector. Different local authorities use different reference prices for personal and social care without really justifying or explaining how this is set. The funding mechanism via APA makes prices for the same service vary within and between local authorities.

5.1 Price setting for skilled nursing facilities

Until 2017, skilled nursing facilities (SSR) were funded by annual prospective global budgets in the public and private non-profit sectors and through a fixed daily rate in private for-profit facilities. Since 2017, the global budgets have been adjusted to take into account the volume and case-mix of the patients treated. This is done by using a patient classification system that applies the logic of homogeneous medical resource groups as in DRGs (diagnosis related groups) in acute care hospitals. Since 2010, a common classification system proposing 750 groups called GME (*groupes médico-économiques*) has been used for monitoring services provided in these institutions. The GME are determined by a number of variables including principal and secondary diagnostics coded at admission, age, post-surgical care, level of dependency of the patient and medical procedures.

The funding reform started in 2017 (i.e. seven years after the development of the first classification and costs-base in SSR) and has been implemented very slowly. In 2020, only 10% of the budget came directly from activity-based payments using GME reference tariffs. The average costs for full or partial hospitalizations were calculated using data from the national cost study (ENC), which included 71 voluntary facilities (of which 30 were private for-profit) in 2017. Reference costs for different groups of patients have been estimated and updated annually by ATIH (Technical Agency for Hospital Information). The reference prices are set following a similar process to the one for the DRG tariffs in acute care hospitals, but there are a few differences. First, the scope of GME tariffs includes all personal costs both in public and private facilities whether they are salaried or self-employed. Second, there is a specific code for stays longer than 70 days, which allows facilities to bill some of the costs gradually. Moreover, the prices are weighted by an index of specialization taking into account the overall case-mix of the facilities. As in the acute care sector, prices are also weighted by a geographic coefficient for the Parisian area, Corse and overseas departments. Since 2018, the SSR can also benefit from the small pay-for-performance scheme used for acute-care hospitals. The performance indicators concern mostly patient safety and relate to structure and organization.

5.2 Price setting for residential care facilities

5.2.1 Residential nursing homes

Historically, the budget for nursing homes was negotiated according to the volume objectives of facilities and on the basis of past expenditures. Residential care facilities for older people, whether private for-profit, private non-profit or public are paid by a three-part tariff: a medical care package, LTC (or dependency) bundle and an accommodation fee.

The funding model gave very significant power to local authorities and to regional health agencies which adjusted the funding. At the end of each year based on the budget results, they both either recover any surplus or cover the deficits. Therefore, the facilities had no incentive to be efficient, but rather to spend more to assure future funding. The SHI fund that finances the health care package was the first to change the base for funding by linking the budgets to the activity and case-mix as early as 2007. The funding method was further changed in 2017, when the dependency bundle was also based on the actual case severity.

The medical care package

The medical care package is calculated for each facility using a synthetic indicator, called weighted iso-care group (GMPS), which corresponds to the average care needs and dependency level of people living in the facility. Care needs are measured by the coordinating doctor of the facility using a classification called "pathos" that identifies 50 clinical conditions with 12 profiles of care required by these conditions constituting 238 couples of "condition-profiles" (Ducoudray et al. 2017). For each of these condition-profiles, eight resource groups were identified (physician, psychiatrist, nursing, rehabilitation, psychometrics, biology, imaging and pharmacy) that define the level of care resources required. For health professionals, this corresponds, for example, to the time required for patients with a given profile. The average resource level required for each of the 238 couples was defined by specialists (geriatric physicians) and reported in terms of points per cost item. For example, for the couple "heart failure" with a profile "close monitoring", the specialists estimated that it requires 13 minutes of geriatrician time a day, 36 minutes of nurse time, etc. The average pathos score (PMP) is the sum of the points of care required in eight resource groups (RG) weighted by a coefficient depending on an RG expressed on average per individual. The care bundle is also adjusted by the dependency level, which is calculated by the AGGIR (Gerontology Autonomy and Iso-Resource Groups) model, which assesses the autonomy of a person for carrying essential daily activities (CNAMTS 2008). The GIR is based on 10 variables of physical and mental activity (coherence, orientation, toilet, dressing, food, etc.) and seven variables of domestic and social activity (cooking, housekeeping, transport, etc.).

Table 4
Prices in residential care facilities

		Dispersion		
		10th percentile	Median	90th percentile
Residential nursing homes (euros/day) *				
The health care package (euros/day)		27.4	32.9	42.8
LTC/dependency bundle (euros/day)	GIR 1-2 (high dependency)	16.9	20.4	24.2
	GIR 3-4 (mid dependency)	10.7	12.9	15.4
	GIR 5-6 (low dependency)	4.6	5.5	6.5
Accommodation fee (for a simple room) (euros/day)	Places habilitated to social assistance	49.2	56.2	66.8
	Places non-habilitated to social assistance	63.0	82.2	106.0
Social residence ** (prices for one room apartment and services)				
Social residences	Places habilitated to social assistance (euros/day)	16.3	23.3	43.8
	Places non-habilitated to social assistance (euros/month)	398.0	581.8	1000

*2017; **2015

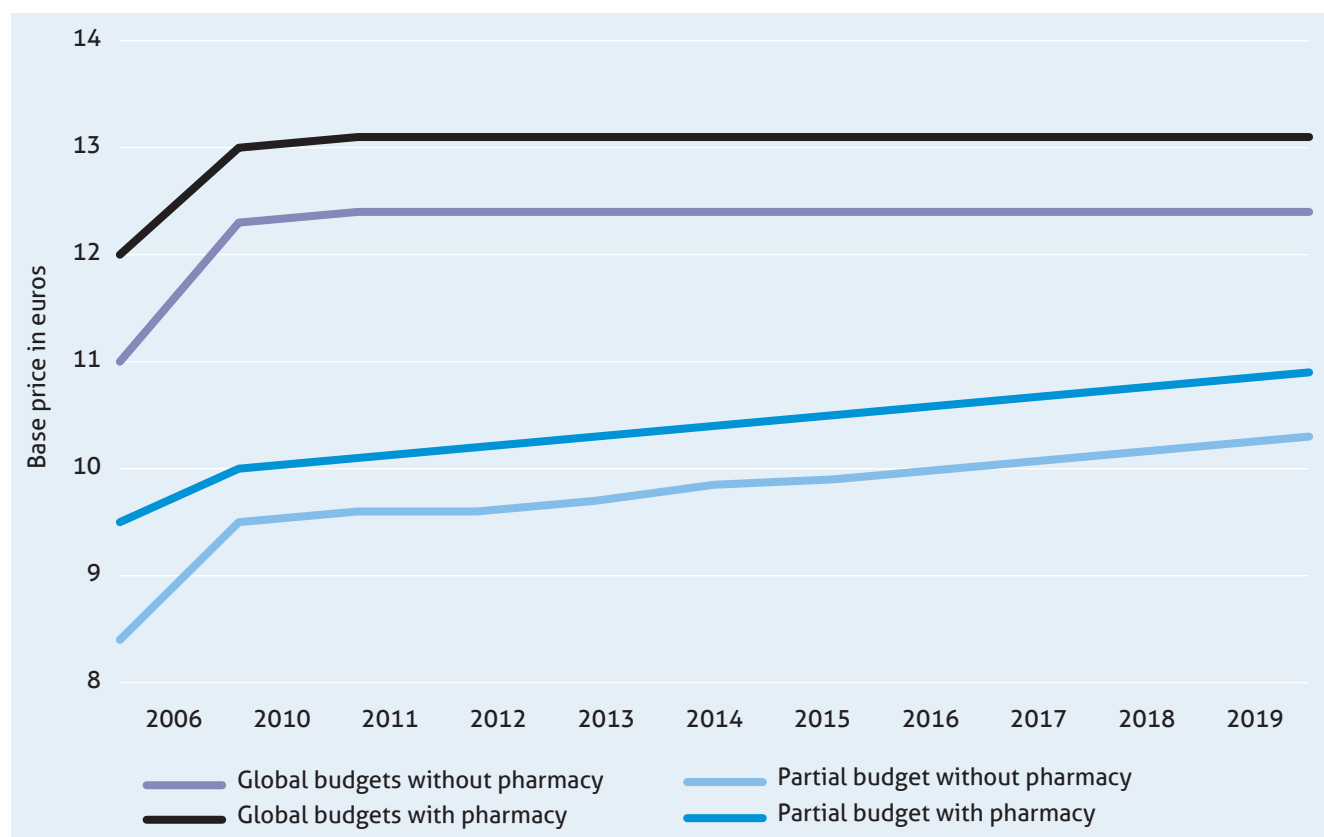
Sources: EHPA database¹² (2015); Moreau and Toupin (2018).

The amount of the medical care package for each facility is the weighted average score (GMPS) multiplied by a reference/index price per point defined at the national level (valeur du point) by the Ministry of Health. There are four different index prices for four different types of nursing homes: those with partial budget where only the cost of the inpatient medical care team is funded, those with global budgets where funds cover also the cost of outpatient care providers such as the general practitioner (GP), physiotherapist, biology and radiology. The nursing homes can also own their own pharmacy; in this case, the funding covers the expenditure for the medications. In 2016, 71% of nursing homes were in partial budget without a pharmacy (drug expenditures paid directly by SHI), 16% of nursing homes were in global budget covering pharmacy, and 11% in global budget without pharmacy (Moreau, El Amaroui and Toupin 2017). The base prices for global budgets have not changed in the past 10 years (Figure 1), while the prices for partial budgets have increased slightly.

¹² <http://www.data.drees.sante.gouv.fr/ReportFolders/reportFolders.aspx>

In practice, the ARS are constrained in their LTC funding by the ONDAM envelop, i.e. the macro level budget which is allocated to them by the SHI (part 3.1). The regional LTC allocation does not always allow to pay the nursing homes the full amount calculated by the GMPS formula.

Figure 1
Evolution of national base price for medical care for different type of nursing homes between 2006 and 2019 (in euros).



Source: Ministerial decrees

The dependency bundle

The dependency bundle finances the cost of the caregivers in helping with ADL (personal and social care). Historically freely fixed by local authorities, a new national formula was defined to calculate the LTC/dependency bundle in 2017 with the objective of harmonizing the funding rules between nursing homes. The payment is calculated according to the GMP (average GIR score) of the facility and the value of the departmental GIR point fixed by the local council (*Conseil départemental*). The value of the departmental GIR point, that is, the basis for funding by the local authorities which determine the generosity of the allocations for LTC varies greatly between *départements* as a function of local policy and wealth, ranging from €5.7 in the Alpes-Maritimes to €9.4 in the South of Corsica (Moreau and Toupin 2018). In 2017, the price for dependency bundle was on average €5.5/day for low dependency persons, €12.9/day for moderate level of dependency and €20.4/day for highly dependent persons (Table 4).

While this funding reform helped to harmonize payments between nursing homes within a local authority, it did not reduce the disparities in funding between local authorities. The objective set by the government in the future is to have a unique national price for each level of GIR to reduce regional disparities in personal LTC funding. However, these policies intervening on LTC funding and increasing the central control are not always well received by the local authorities.

Accommodation fee

Tariffs for accommodation fees are set freely depending on the “standard of services” offered by the facility (comfort of the rooms, quality of the cooking, etc.) when the facility is not receiving social aid for their residents. Nursing homes with dedicated places to receive social/public aid cannot ask for a higher accommodation price than the one set by the local authorities¹³. The majority (83%) of the facilities, whether private or public, have places eligible for public support (Muller 2017b)¹⁴. However, the maximum prices set vary largely across local authorities from €49/day in the first decile to €67/day at the 9th decile (Moreau and Toupin 2018).

The prices of places that are not eligible for public support are set freely, but the rate of increase is monitored each year and regulated by the central government. In 2017, the maximum rate of increase allowed in residential care prices was set at 0.46%.

5.2.2 Social residence

Social residences regulated by local authorities receive two payments: LTC (or dependency) bundle and payments for the rent of the apartment. The dependency bundle is funded by the CNSA to local authorities which finance the facilities. This funding, managed by the local authorities, allows the social residences to recruit specific personnel or engage external stakeholders for implementing preventive actions (nutrition, dietetics, memory, sleep, physical and sports activities, prevention of falls, etc.). The dependency bundle is fixed by the local authorities depending on each facility's preventive action project and local policies. Services provided in the residence (laundry, meals, etc.) are not funded by the dependency bundle but comprised in the rent. The residential apartment prices are supervised by the local authorities for places eligible for social assistance (ASH). In 2015, the average price of a place eligible for social assistance was €780/per month¹⁵ (ranging from €510 to €1410 per month), while the average price for a one room apartment not eligible for social assistance was €655/per month (from €329 to €1308 per month) (EHPA Database 2015).

13 It is not very clear how these prices are set, but likely to be on local prices and social policy.

14 In the public sector, 100% of facilities had places eligible for social aid (93% for all places). In the non-profit sector, 91% of facilities had places eligible for social aid (73% for all places), and in the private for-profit sector, 41% of facilities had places eligible for social aid (generally for few places).

15 Initially estimated per day: €26/per day.

Prices are freely set for private care homes which are not regulated or financed by the local authorities. Historically, introduced in France in the 1970s, these residences were for the elderly who owned an apartment and paid for complementary service charges included in overall co-property charges. This has evolved in recent years towards a new model where residents (owner or not) pay for specific assistance services (laundry, meals, etc.). There is little information on prices of these social residences with services.

5.3 Price setting for LTC services at home

LTC services at home are provided by several professionals often providing the same or otherwise complementary services but paid on a different basis.

5.3.1 Self-employed nurses

Self-employed nurses are paid on a fee-for-service basis by the SHI. The prices of nurse practice acts and their evolution are fixed by the SHI in negotiation with the representatives of self-employed nurses (which are not very powerful in France). The prices are defined for three types of basic nursing acts using a general nomenclature of professional acts (NGAP). The first one, called "medical nursing acts" (AMI), refers to technical acts relating in particular to wound management, injections and swabs. In NGAP, there are 16 groups of AMI corresponding to a combination of one to 15 acts. The price of AMI acts varies from €3.15/act (for example, a simple injection) to €47.25/act, equal to 15 AMI (for example an infusion session lasting more than one hour with continuous monitoring for people with cancer). The second one, called "nursing care acts" (AIS), refers to acts of assistance with ADL (hygiene and surveillance). There are five nursing care acts, and prices depend on the level of need and time required (hygiene or surveillance). In 2019, the AIS base price was €2.65. AIS act prices ranged from €7.95 for 3 AIS, for example, for a half an hour care session, to €42.4 for 16 AIS for constant surveillance at home between 8 p.m. and 8 a.m. Finally, there is a specific act, called "nursing approach" (DI), which pays €10, with a maximum of five prescriptions per year to prepare a nursing care plan for the person. There are extra payments for night and weekend work, distance traveled, single acts and for coordination (Table 5).

Table 5
Prices (in euros) for self-employed nurses (2020)

Nurse practice base price		
Medical nursing acts (AMI)		3.15
Nursing care acts (AIS)		2.65
Nurse planning (DI)		10.00
Extra payments		
Night work	From 8pm to 11pm and from 5am to 8am	9.15/act
	From 11pm to 5am	18.30/act
Weekend		8.50/act
Distance traveled		2.5/person + 0.35 / per kilometre
Single act		1.35/act
Coordination		5.00/act

Source: Ameli (2020)

From fee-for-service to per-day fee

In the latest negotiations voted in March 2019, it was decided to replace the prices of the AIS by a per-day fee. This reform will be applied gradually from 1 January 2020 first only for people over 90 years old, with an objective of generalization in 2023. Three daily prices are fixed depending on the person's level of dependence: €13/per day for low dependency, €18.2/per day for intermediate dependency and €28.7/per day for high dependency. Nurses may, in addition to these packages, invoice certain technical acts (from 1 May 2020).

5.3.2 Home-care nursing services (SSIAD)

Home-care nursing services are funded by the regional health agencies from the regional budget allocated to ARS by the CNSA using a needs-formula taking into account demographic and socioeconomic parameters such as the number of APA allowance recipients and the average income of the elderly in the region. The ARS finance home-care nursing services on the basis of a fixed allocation per installed place. This "capitation" type of payment is operated through a flat-rate allocation per place/per patient and is not adjusted by the care needs of the patients (age, dependency, etc.). The only elements taken into account by the ARS in defining budgets are the salary costs, travel and other operating costs (supplies, etc.) in these services. Thus, the SSIAD are pushed to select their patients in order to maintain their budgetary balance.

The only cost study on SSIADs dates from 2008 (Chevreul et al. 2009) and shows that there is great heterogeneity in the type of care provided per patient and costs, which vary in a range of 0.1 to 3.5 times the amount of the average payment per patient

allocated by the ARS. This study points to the difficulties encountered in the field by these services.

Since 2012, the government has been negotiating to fix a national formula based on the activity and case-mix of the service providers, but without success. A new proposal for a national formula is supposed to be made soon after a cost survey carried out in these facilities in 2018 (ATIH, 2018).

5.3.3 Personal care and assistance at home

Personal and social care services can be funded by APA at home using home care and support services (SAAD), self-employed domestic help or in day-care facilities. For some of these services, the local authorities define reference prices. When prices are free, local authorities use the APA price as the reference for calculating the amount/budget of “care plans”. There are quite large disparities in APA reference prices across local authorities and across LTC providers (SAAD, self-employed domestic help and day care) within local authorities.

Price setting for SAAD

SAAD are statutory services authorized and regulated by local authorities. In a minority of cases (for 23% of SAAD) the prices are fixed by the *département*, while the rest of the services set their own prices (Libault 2019). When fixed by the local authorities, the prices seem to reflect historical costs, but there is not much information on price setting process. In any case, there are significant disparities in prices, pricing processes and rules between local authorities. Most local authorities use different reference prices depending on the activity of SAAD¹⁶, for example, taking into account their services in weekends and public holidays. Across local authorities, there are also differences in the method of payment; some set global budgets (although without a clear basis), while others provide funding on the basis of the number of hours worked per elderly person in APA. Within the local authorities, which use a fixed reference price for LTC for all SAAD providers, the price varies from €13/hour to €22/hour (Table 6).

The majority of SAAD fix their own prices and propose a global budget to the local authority based on an estimated volume to obtain the authorization. If the operating costs presented is too high compared with the prices in the other authorized SAAD or for the budget of the local authority, the authorization can be refused. The rate of increase in SAAD tariffs from one year to the next is regulated nationally. For example, in 2020, the prices cannot grow more than 3%. People benefiting from APA in fixed priced SAAD do not pay any additional charge other than APA co-payment (see section 3.1). In other services, the difference between the price fixed by SAAD and the APA reference price (fixed by the local authority) is paid by the recipients. Therefore, APA prices influence indirectly the prices in the LTC market.

¹⁶ In 2015, only 25% of the local authorities had the same price for all SAAD.

In 2016, the average price charged by SAAD was €20/hour (of which €19 was paid by APA) (FEDESAP 2018). The latest reforms implemented in 2015 as well as the experiments launched recently aimed to develop a global budget for funding SAADs on the basis of multi-year contracts negotiated between the local authority and SAAD to set service objectives and resources needed.

Table 6
APA reference prices for different personal (non-medical) LTC providers

	% of local authorities using fixed prices	Variation in price across local areas	
		Lowest price	Highest price
Home-care and support services (SAAD)	25%	€18/h	€29/h
Self-employed domestic helpers	100%	€8/h	€13/h
Day care in nursing homes	49%	€14/day	€59/day

Note: For funding home-care and support services (SAAD), 25% of local authorities in France use fixed prices (same price for all SAAD in the territory), while 75% negotiate prices individually with each SAAD. Across local authorities using fixed prices, the prices range from €18/hour to €29/hour.

Source: Solvapa database (2015).

Prices for Self-employed domestic help

Prices for self-employed domestic help are freely fixed on the market respecting the French labour code (minimum wage, social security contributions, etc.). To be included in the “care plan” of APA, the self-employed workers need to be accredited by a regional labor and employment agency (DIRRECTE). Local authorities fix an APA reference price for self-employed domestic help. This is the amount reimbursed from APA to people employing self-employed domestic aid, but the actual prices can be much higher. The reference prices for self-employed help are much lower than those in SAAD, ranging from €8 to €13/hour, because local authorities support the deployment of SAAD in which they can control the care standards.

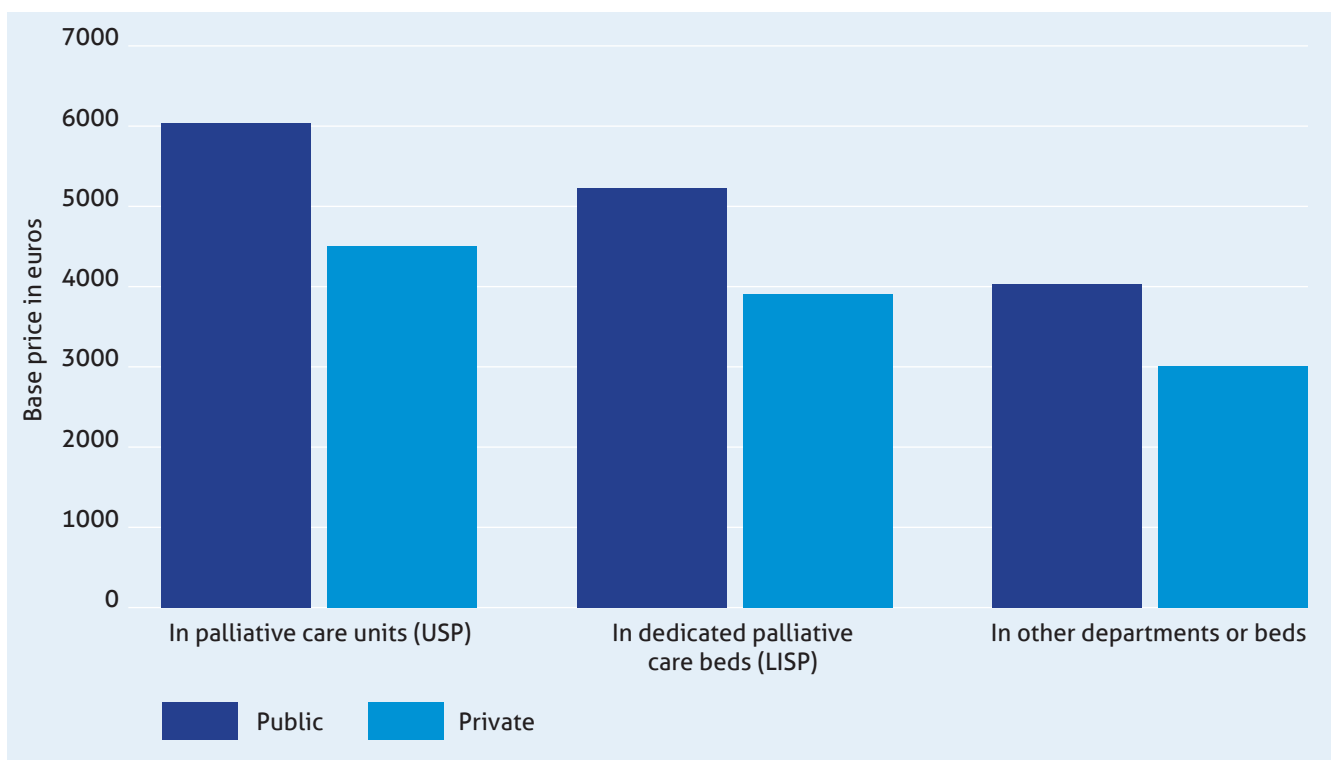
Prices for day care centres

The prices of day-care services often provided in residential nursing homes are freely set by the providers. Day care can be funded by the local authorities in the individualized “care plan” of an APA within the limit of a maximum amount fixed nationally (see part 3.1.2). The APA price of day care used in calculating the “care plan” varies between local authorities. A survey from 2015 showed that 9% of local authorities did not propose any funding for day care, 49% proposed a fixed price (same for all day care centres in the territory), and 43% had varied prices depending on the day-care centre. In local authorities which fixed a reference price, the prices varied between €14 per day to €59 per day (Table 6).

5.4 Price setting for palliative care

The funding of palliative care in the hospital is based on the DRG-based payment, which fixes a price per palliative care stay. The prices are adjusted upwards if a patient is in a dedicated palliative care bed or in the palliative care unit within the hospital (see Figure 2). Prices also differ between public and private hospitals as any other acute care. The mean price is further adjusted downward for very short stays (< 4 days) and increased in cases of long stays (> 12 days). This upper bound was set at the median length of stay, which was 12 days (Veran 2016). According to ATIH cost data, palliative care in hospitals is overpaid with DRG prices by almost 98%, or just over €50 million at the national level.

Figure 2
Prices for palliative care in acute care hospitals 2019 (in euros)



Source: ATIH (2019).

The palliative care in HAH, is also paid by an activity-based payment scheme using palliative care DRGs. In 2019, the price was fixed at €105/per day (ATIH 2019). The price is slightly reduced for people receiving HAH in residential care facilities (-13%) and for those receiving home nursing care from SSIAD (-7%).

Mobile palliative care teams (EMSP) are funded by global budgets. The price is set by the ARS according to the number of full-time-equivalent persons working in the team and considers the travel costs. The payment also includes a contribution to the structural costs of the hospital that the team is attached to. The amount of payment for organizational costs may be assessed by the ARS on the basis of hospital accounting data.

6

Issues and evaluation

With a multitude of care providers funded and regulated by different institutions at different levels of government using different payment rules, the French LTC system is complex. This complexity has several consequences in terms of the cost, quality, accessibility and equity of LTC services.

6.1 Cost and accessibility of LTC

Medical LTC services are funded by SHI from different envelopes defined at the national level (ONDAM) and distributed by using different rules. The majority of medical LTC providers at home are paid on a fee-for-services basis, which is inflationary and difficult to regulate (Cour des comptes 2018). Between 2012 and 2016, spending on self-employed nurses increased by about 25% (€1.2 billion). On the other hand, personal and social LTC services are funded and managed by the local authorities, which have different level of resources and policies for LTC. While the cost of medical LTC services are covered relatively well by SHI, the cost of personal/social care services faced by older people and families could be quite high. The solvency of the residential facilities and platforms providing LTC services at home depends on the base prices fixed at the national or local level. However, the prices used for paying these providers vary largely within and between local authorities, and they appear to be mostly disconnected from the actual costs of care for providers. In nursing homes, where the national reference price has not increased since 2009, the main margin for balancing the budget is increasing the accommodation fees. The average out-of-pocket costs left to residents estimated to be around €1850, and this exceeds the monthly income of three residents out of four (Libault 2019). There are also significant disparities across local areas in the availability of LTC services at home and in residential facilities. The place of private providers and the out-of-pocket payments for the recipients are very much linked to the political colour of the local authorities, who define largely the LTC policy.

6.2 Coordination of LTC services

Improving the coordination between existing institutions, funding schemes and care providers has been on the policy agenda for a long while. Different initiatives (such as MAIA¹⁷ for people with complex care needs including Alzheimer's disease

¹⁷ MAIA (Maisons pour l'autonomie et l'intégration des malades Alzheimer) were initially created by the Alzheimer Plan 2008-2012 as pilot structures. They are intended to coordinate the care for people suffering from Alzheimer's disease and to support caregivers by developing new management strategies. They were renamed in 2016 as "Methods for action for integrating long-term care and social services" in order to target a larger population with complex needs, to improve the continuity of care in complex situations where many professionals from different disciplines (social, medico-social and health sectors) are handling high-need patients and to support home care.

and PAERPA¹⁸ for the population over 75 years old) that aimed to improve the coordination of local actors involved in LTC for complex elderly people have had only limited success (CNSA 2017; Or et al. 2020). The creation of successive measures with more or less the same objectives without a coherent population-based policy appears to create confusion both for the actors concerned and the LTC users.

Moreover, the measures proposed by the central government and executed by the ARS are not always supported by the local authorities. The collaboration (or lack of it) between the ARS and the “département” impacts directly the organization of the LTC services, their coordination and efficiency at the local level. In order to improve the collaboration between different financing institutions and encourage the coordination of LTC actors at the local level, a new body was created in 2015, “Conference of the funders preventing loss of autonomy of the elderly” (*conférence des financeurs de la prévention de la perte de l'autonomie des personnes âgées*). The funders’ conference had the ultimate objective of sustaining the financing of the LTC sector by better coordinating the services at the local level. It had three main missions: providing an overall diagnostic of care needs for the elderly population in France, identifying ongoing local initiatives for improving care coordination, and defining a coordinated program for funding actions aiming to prevent the loss of autonomy. The CNSA supported the actions defined by the conference of funders with about €140 million in 2018, but it is not really clear what are the priority measures to be financed and how these will be defined.

6.3 Care quality

The lack of information on costs and quality of care of different providers is an important problem both for the funders and users. Globally there are very few cost studies on home-based LTC services in France. But even when there is a cost survey, it is not clear how and if the quality of care is taken into account and what the link is between these cost studies and the prices used for funding.

Since 2002, social and medico-social facilities have been required by law to carry out regular assessments of their activities and quality of the services they provide. The National Authority for Health (HAS) provides recommendations of good professional practices in the social and medico-social sectors. The facilities have to carry internal evaluations (three evaluations every five years) as part of the process of continuous quality improvement. They also need to have an external evaluation carried out by a private organism of their choice but only once

18 PAERPA (Healthcare Pathways for Seniors, *Parcours de santé des aînés*) launched in 2014 in nine pilot territories with the objective of improving coordination at the local level of various health and social care providers for better care management of the population over 75 years old in order to prevent a loss of autonomy and avoid inappropriate hospital and drug utilization. While the measures are well defined and financed within the framework of the experimentation, they are implemented quite unequally from one area to other.

every five to ten years¹⁹. There are also no clear recommendations for quality indicators to monitor these evaluations. There are a few surveys collecting data on the conditions of nursing care homes and patients' well-being in these facilities, but data from these surveys are not available to public (ANAP 2019; Anesm 2015; Drees 2015). There is almost no public information on the quality of individual nursing care facilities.

In the past ten years, while there has been a shift from using global budgets simply based on historical costs towards adjusting payments by the volume and case-mix of patients cared for, the care quality does not appear to be integrated into payment yet. Recently, two national agencies (ANAP, ATIH) have developed a panel of quality indicators to use in the LTC sector in order to help the ARS and local authorities to better monitor and negotiate the budgets with care providers (in CPOM). However, the indicators proposed relate mainly to overall activity (bed-occupancy, type of authorized places, turnover rate of residents, etc.), staff structure (staff turnover rates, absenteeism rate) and financial situation (debt ratio, etc.).

For the users, there is almost no information on the quality of different LTC providers (nursing homes or homecare services). The government has set up since 2016 a website which allows viewers to consult the prices and out-of-pocket payments in residential nursing homes and in social residence, but there is no information available on the quality of care. It is quite difficult for older people and their families to identify best providers and decide what will be the most appropriate care solution for them. One measure put forward in PAERPA is the creation of a unique local information platform for elderly populations, their families, and care providers involved in LTC. While these platforms help the users and health and social care professionals identify available services in their territory, it would be important to make the available services easier to assess and develop quality indicators which reflect the experiences of LTC users and their families.

6.4 Evaluation of recent reforms

Faced with an increasing demand for LTC, the 2015 Act on adapting society to an ageing population aimed to deal with the challenges of sustaining a high-quality LTC sector. This Act had the objective of reinforcing the provisions for LTC care at home and delaying as much as possible nursing home stays. The key proposals were to increase APA funding at home, to recognize the role played by the informal family caregivers by supporting them financially, to improve the coordination between medical and social LTC actors and to strengthen prevention for maintaining the autonomy of the elderly population. Only a few actions concerned residential care facilities, one of which was the creation of a website for elderly persons and their families, allowing them to compare the prices of residential care facilities. An evaluation carried out in 2017 evoked two positive impacts of the measures introduced

¹⁹ From a list of certified organizations.

(Firmin le Bodo and Lecoq 2017). First, the increase in APA allowances contributed to reducing out-of-pocket payments of the users. Second, “informal careers” who provide significant support to elderly and younger persons who need help with ADL are defined formally, and their investment in LTC provision is officially recognized, with financial measures for supporting their involvement. Nevertheless, the financial measures introduced for helping informal careers are deemed insufficient (Firmin le Bodo and Lecoq 2017).

In 2019, a grand consultation was carried out among LTC actors to make concrete propositions to improve the quality of services and the sustainability of finance in the LTC sector (Libault 2019). While supporting the efforts already made in the previous laws for strengthening home care and helping informal caregivers, this consultation highlighted two important issues overlooked until now. The first is the increasing difficulty of recruitment in the LTC sector because of difficult working conditions, low wages and the lack of recognition of care providers. The second issue raised is the need for improving the quality in residential nursing homes, the need for increasing the staff ratios, renovating the structures, etc., while reducing out-of-pocket payments (Destais N 2013). This consultation also showed the need to integrate LTC care services at home and in residential care facilities. Indeed, in the past couple of years, several experiments at the local level have tested the possibility of using residential nursing homes as a technical platform for elderly people staying in their home (i.e., outsourced nursing home services for elderly people at home). The parliament was planning to discuss these recommendations in March 2020. Sadly, the COVID-19 crisis and the high dead tolls in nursing homes in France during the first wave of pandemic proved how pertinent these observations are and showed the urgency of improving the connection at the local level between LTC providers in different settings.

Consequently, the government recognized ageing as a new risk and a new branch (autonomy) for social insurance adding to the first four (health, family, employment, retirement) by the law of August 7, 2020. This law shifts the responsibility for national regulation and funding of medical LTC from SHI to CNSA, and it increases the power of the CNSA in piloting LTC in France. However, the creation of the 5th branch does not modify the structural weaknesses of the LTC funding in France, and it does not help to reduce regional inequalities in financing LTC. The funding of personal and social LTC services remains under the responsibility of local authorities and varies according to their political program and wealth. Moreover, the local governance of LTC shared between the ARS and local authorities, which have very weak connection, appeared to be particularly problematic during the COVID-19 crisis. Thus, all the questions raised during the conference of funders and in this chapter on adequacy of prices and financing, quality of care and sustainability of out-of-pocket payments for long-term care are more than ever on the political agenda in France.

Conclusion

The French LTC sector is complex with multiple funders and care providers managed by different levels of government. While the SHI system allows a unified and relatively good coverage of medical LTC needs, the type and funding of the personal and social LTC services vary depending on the local authority. This has resulted in large differences across French *départements* in prices of personal LTC services and out-of-pocket payments faced by the recipients.

Prices and payment mechanisms used for funding providers vary also for medical and personal LTC services. While for medical LTC services the payments are usually adjusted by taking into account the severity of the patients cared for, this is not always the case in personal and social care sectors. Regardless, none of the payment mechanisms take into account the quality of service providers. Generally, there is very limited information on actual costs and care quality of the LTC providers. This hinders both the scope for improving the quality of LTC services and the efficiency of care provision in the LTC sector.

References

- Ameli (2020). L'Assurance Maladie, Tarifs conventionnels applicables aux infirmiers libéraux (à compter du 1er janvier 2020). <https://www.ameli.fr/infirmier/exercice-liberal/facturation-remuneration/tarifs-conventionnels/tarifs>
- ANAP (2019). Le tableau de bord de la performance dans le secteur médico-social. Mieux se connaître et dialoguer sur son territoire. (https://www.anap.fr/fileadmin/user_upload/outils_et_publications/Outils/Accompagner_le_secteur_medico-social/Organisation/tdb_ms/plaquette_tdbms2019.pdf) [in French]
- Anesm (2015). Bientraitance des personnes accueillies en établissements d'hébergement pour personnes âgées dépendantes : analyse des résultats. [in French]
- Arnault L (2019). Montants d'APA à domicile depuis 2011: une réallocation au bénéfice des plus dépendants. *Etudes et Résultats*. Drees, n°1118. [in French]
- ATIH (2018). Synthèse : analyse de l'activité hospitalière 2017. *Agence technique de l'information sur l'hospitalisation*. Novembre. [in French]
- ATIH (2019). Financement et données financières. <https://www.atih.sante.fr/tarifs-mco-et-had>
- Bennet L and Fontaine R (2017). Rapport annexe de la Commission de travail sur le recours aux financements privés dans la couverture de la perte d'autonomie. *Rapport conseil de l'âge*, HCFEA. Décembre. [in French]
- Bohic N, Fellingier F, Saie M and Viossat LC (2019). Evaluation du plan national 2015-2018 pour le développement des soins palliatifs et l'accompagnement en fin de vie . *Rapport*, IGAS RM2018-140R. [in French]
- Brunel B and Carrère A (2017). Les personnes âgées dépendantes vivant à domicile en 2015, Premiers résultats de l'enquête CARE ménages. *Etudes et Résultats*. Drees, n°1029. [in French]
- Chevreul K, Bahrami S, Lucier S, et al (2019). Les patients en service de soins infirmiers à domicile (SSIAD), Le coût de leur prise en charge et ses déterminants. Unité de recherche clinique en économie de la santé d'Ile de France. (<https://travail-emploi.gouv.fr/IMG/pdf/SSIAD.pdf>) [in French]
- CNAMTS (2008). Le modèle "AGGIR" : Guide d'utilisation. Assurance maladie 2008. [in French]
- CNAV (2019). La sécurité sociale: L'assurance retraite 2018. *Rapport action social*. Juin. [in French]

CNSA (2019). Concours allocation personnalisée d'autonomie. (<https://www.cnsa.fr/budget-et-financement/concours-aux-departements/concours-allocation-personnalisee-dautonomie>) [in French]

Cour des comptes (2015). La sécurité sociale: Rapport sur l'application des lois de financement de la sécurité sociale. *Rapport*. Septembre. [in French]

Cour des comptes (2018). La sécurité sociale: Rapport sur l'application des lois de financement de la sécurité sociale. *Rapport*, Cour des comptes. Octobre. [in French]

Delatre A and Paul S (2016). Les unités de soins de longue durée USLD. *Rapport*, IGAS, RM2013-121P. [in French]

Destais N (2013). Financement des soins dispensés dans les établissements pour personnes âgées dépendantes (EHPAD) : Mission complémentaire d'évaluation du tarif global de soins . *Rapport*, IGAS, RM2013-121P.

Ducoudray JM et al. (2017). Le modèle « PATHOS » Guide d'utilisation 2017. CNSA.

Drees (2015). L'enquête auprès des établissements d'hébergement pour personnes âgées (EHPA). (<https://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/open-data/etablissements-de-sante-sociaux-et-medico-sociaux/article/l-enquete-aupres-des-etablissements-d-hebergement-pour-personnes-agees-ehpa>). [in French]

EHPA Database 2015. <http://www.data.drees.sante.gouv.fr/ReportFolders/reportFolders.aspx>

FEDESAP (2018). Tarif APA : Étude des réalités départementales. *Rapport*, Observatoire national du domicile. Mai. [in French]

FEHAP (2017). Vers le SPASAD 3.0: Etat de l'art d'un système d'information urbanisé. *Livre blanc*, FEHAP. [in French]

FIR (2019). Fonds d'intervention régional : Rapport d'activité 2018. *Rapport*, Secrétariat général des ministères chargés des affaires sociales. Octobre. [in French]

Firmin le Bodo A and Lecocq C (2017). Rapport d'information déposé en application de l'article 145-7 du Règlement par la commission des affaires sociales sur la mise en application de la loi n° 2015-1776 du 28 décembre 2015 relative à l'adaptation de la société au vieillissement. [in French]

Insee (2020). Estimation de la population au 1^{er} janvier 2020, Séries par région, département, sexe et âge de 1975 à 2020. (<https://www.insee.fr/fr/statistiques/1893198>) [in French]

Le Bihan B and Martin C (2018). French social and long-term care system. *Global Social Security Review*, Korean Institute for health and social affairs (KIHASA) 7:5-15.

Leroux I et al. (2017). L'aide et l'action sociales en France. *Panorama*, Drees. [in French]

- Leroux I et al (2018). L'aide et l'action sociales en France. *Panorama*, Drees. [in French]
- Libault D (2019). Concertation Grand âge et autonomie. Ministère des solidarités et de la santé. [in French]
- Moreau C, El Amraoui N and Toupin MH (2017). La situation des EHPAD en 2016 : Analyse budgétaire de la prise en charge des résidents en EHPAD. *Rapport*, CNSA. Novembre. [in French]
- Moreau C and Toupin MH (2018). Les prix des EHPAD en 2017. *Analyse statistique*, CNSA, n°5. [in French]
- Moreau C and Toupin MH (2019). La situation des EHPAD en 2017: Analyse de la gestion des établissements d'hébergement pour personnes âgées dépendantes et de la prise en charge des résidents. *Rapport annuel*, CNSA. Avril. [in French]
- Muller M (2017a). 728 000 résidents en établissements d'hébergement pour personnes âgées en 2015. Premiers résultats de l'enquête EHPA 2015. *Etudes et Résultats*, Drees, n°1015. [in French]
- Muller M (2017b). L'accueil des personnes âgées en établissement: entre progression et diversification de l'offre Résultats de l'enquête EHPA 2015. *Les dossiers de la Drees*, Drees, n°20. [in French]
- Muller M and Roy D (2018). L'Ehpad, dernier lieu de vie pour un quart des personnes décédées en France en 2015. *Etudes et Résultats*, Drees, n°1094. [in French]
- Mure C (2018). Résidences services seniors: mieux vieillir «chez soi» au cœur des territoires. *Livre blanc*, SNRA. [in French]
- NIH (2017), National Institute on Ageing, What is long-term care? [Content reviewed: May 01, 2017] <https://www.nia.nih.gov/health/what-long-term-care>
- OECD (2018). Accounting and mapping of long-term care expenditure under SHA 2011. (<https://www.oecd.org/els/health-systems/AccountingMappingofLTC.pdf>).
- Or Z, Bricard D, Penneau A (2020). Que peut-on apprendre de l'évaluation d'impact de l'expérimentation Parcours santé des aînés (Paerpa) ? *Questions d'économie de la santé*, IRDES, n° 252. [in French]
- Penneau A, Pichetti S and Espagnacq M (2018). Le système de protection sociale limite les restes à charge liés aux soins des personnes qui recourent à l'aide humaine. *Questions d'économie de la santé*, IRDES, n° 233. [in French]
- Polton D (2004). Décentralisation des systèmes de santé : un éclairage international ; 2004. *Revue française des affaires sociales* 4:267-299. [in French]
- Rondinelli DA, Nellis JR and Cheema S (1983). *Decentralization in developing countries: a review of recent experiences*. World Bank Staff working paper, n° 581, World Bank.

Sécurité sociale (2019). Annexe 7: ONDAM et dépenses de santé. PLFSS 2019, Sécurité sociale. [in French]

Shepperd S and Liffe S (2005). Hospital at home versus in-patient hospital care; 2005. *Cochrane Database of Systematic Reviews* 3. Art. No.: CD000356. DOI: 10.1002/14651858.CD000356.pub2.

Sovapa Data base (2015). http://www.data.drees.sante.gouv.fr/ReportFolders/reportFolders.aspx?IF_ActivePath=P,545,546

Statis. Health and Social Statistics and Indicators. Database. https://www.scoresante.org/tab_statiss.aspx

Vachey L, Allot F, Scotté N (2020). La branche autonomie : périmètre, gouvernance et financement, Inspection Général des Finances, Public report [in French].

<https://www.vie-publique.fr/sites/default/files/rapport/pdf/276269.pdf>

Veran O (2006). Mission sur l'évaluation du mode de financement des établissements de santé. Rapport d'étape, Stratégie santé. [in French]