



What Public Policy for the Dependent Elderly?

Les notes du conseil d'analyse économique, no 35, October 2016

The number of people over 65 in situations of dependency varies from 1.24 million if one refers to the number of Long term care allowance (*Allocation personnalisée d'autonomie*, APA) claimants, to close to 3.3 million according to an epidemiological assessment. The resulting costs of dependency in terms of health care, accommodation and informal assistance are between 41 and 45 billion euros per year of which 23.5 billion, or about one percentage point of GDP, come under public expenditure. The latter is expected to increase by around + 0.3 to + 0.7 percentage points of GDP by 2040, based on demographic and epidemiological projections.

In the wake of this trend, public policy needs to conciliate sometimes contradictory objectives: improve the quality of elderly care, provide effective and fair coverage for dependency risks, and contain state expenditure. The *Adaptation de la société au vieillissement* (ASV, Adaptation of society to aging) Act, entered into force on 1st January 2016, is a significant step toward meeting this challenge. However, additional measures would alleviate persistent weaknesses of the current system, namely deficiencies in terms of its regulation, transparency, diversity and competitiveness on the supply side, low job attractiveness of the sector, and inconsistencies in public aid.

Two major courses of action could improve the provision of care services: on the one hand, establishing minimum standards of treatment in nursing homes, and on the other hand collecting and sharing information about the

quality of care. This would allow the regulator to gain greater control and adjust the pricing, while providing an incentive to nursing homes to improve their services when confronted with better-informed patients. The increase and diversification in the provision of nursing accommodation require an easing of the legal framework for extending the sector, and a better analysis of the potential demand for assisted-living accommodations. Lastly, it is important to supplement efforts to promote job training in the sector by reevaluating career developments and improving working conditions.

It would also be worth changing the way dependency is financed. In theory, the French system is organised in such a way as to guarantee freedom of choice for the dependent elderly. In practice, differing support schemes for health care, assistance and accommodation expenditures largely condition this choice and impair the efficiency and fairness of the system. The authors propose two options for reform. A first option suggests to align government funding on the most efficient type of care provision, developing an extended care allowance which would apply the same coverage to all expenditure attributable to dependency care, including additional costs of accommodation. In addition, the introduction of dependency loans would better mobilise household assets to bear outstanding costs. A more ambitious second option would establish an obligatory dependency insurance for cases of serious dependency. For mild dependency, public coverage would cover low income households only.

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The situation

After a national debate in 2011, the *Adaptation de la société au vieillissement* (ASV) Act adopted late 2015, introduced several improvements in the provision of dependency care.¹ This *Note* seeks to clarify diagnosis elements that have been left apart from an in-depth debate, in order to suggest further avenues of reform.

The dependent population: what does it mean?

In French public policy, “dependency” is defined as “the need for assistance in the accomplishment of essential daily tasks” (article L232-1 of the Social care and family code) by the elderly, as opposed to the term “handicap” applying only to younger age groups. This division of policy according to age is a specific feature of the French system. It was established in 1997 with the introduction of the Specific long term care benefit, an elderly-specific benefit, replaced in 2002 by the Long term care allowance (*Allocation personnalisée d'autonomie*, APA). An assessment of the number of people affected by dependency varies according to how it is defined: the French administrative definition (based on recipients of APA benefits) gives an estimate of just over a million people, whilst epidemiological definitions give figures varying from 1.3 to 7 million, depending on the chosen criterion (box 1).

Whilst research carried out in the 1990s and early 2000s highlighted an increase in disability-free life expectancy, more recent studies, in France and in other countries, emphasise a slow-down in this increase compared to the overall increase in life expectancy.² Projections drawn up in France within the framework of the national debate in 2011 focused on an increase in the number of dependent individuals during the next twenty years: the decrease in morbidity envisaged in different scenarios does not compensate for the arrival of the baby boom generation to the ages where a greater incidence of dependency occurs. In the longer term, the projections are more unpredictable and are influenced by the chosen epidemiological scenarios.

Two lessons can be learned from these projections. On the one hand, the increase in the number of dependent individuals justifies an initial policy for reducing the incidence of dependency (research, health, adjustments to living conditions). On the other hand, costs linked to dependency care will increase in the next twenty years, but on a more moderate scale than that mentioned, for example, within the framework of the projections for pension expenditure: on the basis of macroeconomic forecasts comparable to those of the Pensions Advisory Council (*Conseil d'orientation des retraites*, COR), the intermediate epidemiological scenario results in

1. A difficult measure

To determine the number of dependent individuals, there are generally two approaches: one based on the administrative definition of dependency, the other on epidemiological assessments based on specialised surveys.

The administrative approach, predominant in official reports, is based on the number of APA claimants, assessed according to the DREES at 1.24 million on 31 December 2013; three quarters of these are women, half of whom are over 85.^a By design, these figures do not take into account those who do not claim the APA. In addition, they are affected by the criteria for eligibility as defined in the model “autonomy gerontology groups iso-resources” (*autonomie gérontologie groupes iso-ressources*, AGGIR). Yet this model, classifying individuals into six groups (from GIR 1 –seriously disabled– to GIR 6 –autonomous individuals), has been subject to several criticisms: a lack of precision in the transition between the GIR 5 and the GIR 4 thresholds and the classification algorithm’s sensitivity to small variations in the initial coding. It is, moreover, specifically French and is not used in international research.

Epidemiological assessment is based on international standards for the evaluation of functional limitations and restrictions in everyday activities,^b to which a specific evaluation of cognitive capacities is frequently added. The disability and health surveys carried out by the INSEE and the DREES, which use these standards, estimate the number of individuals over 60 who report functional limitation as close to 7 million (representing 48% of those About 3.27 million individuals living at home could be limited in their “instrumental” activities and 1.28 million in their “essential” activities.

^a <http://drees.social-sante.gouv.fr/etudes-et-statistiques/open-data/handicap-et-dependance>

^b Basic everyday activities: functional mobility, washing, dressing, eating meals. Everyday instrumental activities: housework, preparation of meals, taking medicines, managing the budget, shopping, using the telephone or other means of communication, using local transport.

an increase in public expenditure of 0.4 to 0.7 percentage points of GDP by 2040.³ Therefore the key issue is primarily that of the distribution of these costs between public and private funding and the forms state support should take.

The authors would like to thank Manon Domingues Dos Santos, scientific advisor for the CAE, for her invaluable help with the compilation of this *Note*.

¹ Two very comprehensive reports were written at the time of the 2011 national debate on dependence, see Charpin J-M. (mod.) and C. Tili (rep.) (2011): *Perspectives démographiques et financières de la dépendance (Charpin Report)*, Rapport du groupe n° 2 sur la prise en charge de la dépendance, La Documentation française, June, and Fragonard B. (2011): *Stratégie pour la couverture de la dépendance des personnes âgées (Fragonard Report)*, Rapport du groupe n° 4 sur la prise en charge de la dépendance, La Documentation française, juin. See Cour des Comptes (2016): *Le maintien à domicile des personnes en perte d'autonomie*, July. The ASV Act was passed on 28 December 2015, see the site legifrance.gouv.fr

² Sieurin A., E. Cambois and J-M. Robine (2011): “Les espérances de vie sans incapacité en France : une tendance récente moins favorable que dans le passé”, *Document de travail INED*, no 170. Crimmins E., M. Hayward, A. Hagedorn, Y. Saito and N. Brouard (2009): “Change in Disability-Free Life Expectancy for Americans 70 Years Old and Older”, *Demography*, vol. 46, no 3, pp. 627-646.

³ Charpin Report (2011) *op. cit.* pp. 34-36.

Observation 1. The costs of dependency will most probably increase in the next twenty years, however to a much lesser extent than pension expenditures. In the longer term, there is a lot of uncertainty and government policy has an upstream role to play in order to prevent the risk of dependency.

Care for the dependent

Assistance for dependent individuals is based mainly on two types of provision, seen as two successive responses to increasing dependency: provision for individuals living at home and for those living in nursing homes.

Care provision in nursing homes

At 31st December 2011, 693,000 elderly people were living in nursing homes⁴ (table 1). As a consequence of reforms undertaken since 1997,⁵ nursing homes (residential homes for the dependent elderly, établissements d'hébergement pour personnes âgées dépendantes, EHPAD, and long-term health care facilities) today represent almost 85% of the available accommodation, as opposed to 54% in 2003.⁶ The individuals catered for are almost always highly dependent: over 90% need assistance when washing or dressing, over 80% present symptoms of confusion and 25% of residents are under legal protection. The remainder of available accom-

modation (15% i.e. approximately 100,000 places) corresponds to homes providing integrated services (exsheltered accommodation), a hybrid solution which makes it possible to provide communal facilities and professional services for individual housing in communal accommodation. Residents are essentially autonomous or slightly dependent (GIR 6 to GIR 4, see box 1). The ASV Act, which entered into force in January 2016, attempts to enhance this type of accommodation very common in other countries: these purely residential homes accommodate 4% of the elderly population in the United Kingdom and 7% in Canada, as opposed to only 1% in France.⁷

Home-based care provision

Institutional care provision is mainly only for the highly dependent: dependent individuals therefore reside predominantly at their normal home (672,450 APA claimants, i.e. 55% of claimants, cf. table 1). According to the Disability and Health survey, if a broad definition of dependence is adopted, one in two dependent individuals living at home regularly receives professional assistance. Workers differ as much in their area of activity as in their mode of operation. Assistance in the carrying out of daily activities can be delivered by home care assistance and support services or by workers employed directly by those assisted: thus a quarter of APA claimants living at home are private employers. Dependent individuals also receive personal care, provided by care workers and nurses, who may be employees of home nursing care services or independent professionals.

1. Distribution of the elderly per type of care provision and level of dependency, on 31st December 2011

	In nursing homes (aside from assisted-living accommodation) ^a	In assisted-living accommodation ^a	At home ^b
Dependent (GIR 1 to 4)	523,820	23,550	672,450
• GIR 1 (seriously handicapped)	118,530	0	20,880
• GIR 2	205,800	2,050	116,270
• GIR 3	87,970	4,090	149,030
• GIR 4	111,520	17,410	386,270
Mildly dependent or autonomous (GIR 5 and 6)			
• GIR 5	35,730	14,340	—
• GIR 6 (autonomous)	31,030	64,520	—
Total	590,580	102,410	—

Notes: ^a The number of residents of unknown GIR according to the EHPA survey is around 50,000 individuals. The assumption here is that the distribution of these residents per GIR is the same as that of residents whose GIR is known; ^b Who receive the "home" APA (aside from assisted-living accommodation). Those living at home coming under GIR 5 and 6 are not eligible for the APA.

Sources: Enquête EHPA et remontées individuelles (66 départements) and authors calculation.

⁴ Volant S. (2014): "693 000 résidents en établissements d'hébergement pour personnes âgées en 2011", *Études et Résultats, DREES*, no 899, Decmer.

⁵ Act n° 97-60 of 24 January 1997, which defines, in particular, the status of residential homes for the dependent elderly (EHPAD) and the decrees of 26 April 1999 n° 99-316 relating to EHPAD pricing and funding terms and conditions and n° 99-317 relating to EHPA budget management and accountability.

⁶ Tugorès F. (2005): "Les établissements d'hébergement pour personnes âgées en 2003 : activité et personnel. Premiers résultats de l'enquête EHPA 2003", *Études et Résultats, DREES*, no 379 and Volant S. (2014): "L'offre en établissements d'hébergement pour personnes âgées en 2011", *Études et Résultats, DREES*, no 877, February.

⁷ Institut Montaigne (2015): *Faire du bien-vieillir un projet de société*.

Despite these measures and in spite of the increase in the number of hours of home support approved by the ASV Act (an additional one hour per day for the heaviest assistance schemes), care provision for dependent individuals living at home is mainly shouldered by their families, mainly spouses, daughters and sons. Over three out of four dependent individuals are in fact regularly assisted by an informal carer. The median daily duration of this aid is 1 hour and 40 min, as opposed to 35 minutes for official assistance (all levels of dependence): for the most heavily dependent individuals (GIR 1 to 2), the daily durations are respectively: 5 hours and 15 min (informal help) and 2 hours 10 min (official help).

The practical details of the organisation of family support put France and Germany in an intermediary position between the Southern European model and the Northern one. In this regard, the proportion of dependent people living alone at home is relatively small. Whilst children are more involved in France than in Northern countries, Southern countries are characterised by a greater extent of inter-generational cohabitation.⁸

The unknown arbitrage in care arrangements

Choices in care provision depend upon age and the degree of dependence. However, the notion of supply also seems to operate: being able to count on a spouse or a daughter reduces the likelihood of entering a nursing home;⁹ residing in a zone which is well-provided with nursing homes increases it.¹⁰ In fact, available statistics show that certain social and occupational categories, like farmers and executives, enter nursing homes in fewer numbers than others. However, without available extensive longitudinal data, an analysis of the choices in the provision of care remains incomplete. In particular, it is impossible to isolate the effect of arbitrages made for strictly economic reasons relating to the income of individuals and to the amount of capital in their possession, to the form these take (real estate property or financial wealth, retirement pensions or income from investments, etc.), and to the multiple schemes through which public aid intervenes to fund support for dependence (APA, means-tested housing benefit, income tax, etc.).

Observation 2. The majority of the dependent elderly live at home, where family support is crucial. The vast majority of individuals who reside in institutions are heavily dependent. The socioeconomic factors determining the choice of types of care provision remain largely unknown.

The costs and financing of dependence

As the Fragonard report (2011) has shown, it is not obvious how to define the amount of expenditure incurred due to dependency: how can the additional expenditure on health care and accommodation be measured? Should the informal carers' cost to the economy be included? If one adopts the conventions of dependency accounts which retain the additional costs in health care and accommodation attributable to a loss of autonomy, and one adds the cost to the economy of informal care, total cost of dependency amount to between 41 and 45 billion euros (table 2). Government expenditure amounts to 23.5 billion euros i.e. just over one percentage point of GDP, more than half of which corresponds to health care expenditure and about a third to official assistance in day-to-day activities. More than half of the cost incurred by households –between 17 and 21 billion euros– is devoted to informal care and almost a third to accommodation costs.

2. Total expenditure for dependency care provision in billions of euros, 2014

	Public expenditure	Private expenditure	Total
Health care	12.2	0.1	12.2
Dependency (professional care)	8.1	2.4	10.5
Dependency (informal carers)	–	7 to 11	7 to 11
Accommodation	3.3	8.2	11.5
Total	23.5	17.7 to 21.7	41.2 to 45.2

Sources: Darcillon T. (2016): « Le compte de la dépendance de 2010 à 2014 », *La protection sociale en France et en Europe en 2014*, Coll. 'Panoramas de la DREES' and Renoux A., R. Roussel and C. Zaidman (2014): « Le compte de la dépendance en 2011 et à l'horizon 2060 », *Dossiers Solidarité et Santé*, no 50, February.

Within public expenditure, health insurance emerges as the primary state funder, health care expenditures alone representing 12 billion euros in 2014. Dependency *stricto sensu* care provision is delivered *via* the APA (5.5 billion) and to a lesser extent *via* tax and welfare spending (1 billion). In terms of accommodation costs, the bulk of state intervention corresponds to Housing Benefits (*Aide sociale à l'hébergement*, ASH) incurred by the *départements* (1.2 billion). Apart from health care costs, the APA is thus the primary state benefit supporting dependent individuals. There is a significant difference in how it functions for individuals at home and for those in institutions (table 3).

At home, this consists of an allocation to cover expenses relating to a loss of autonomy, defined by an assistance

⁸ In France, around one in ten dependent individuals share their homes with a son or a daughter, compared to 2% in Sweden, 27% in Italy and 35% in Spain.

⁹ Arnault L. (2015): *Prise en charge des personnes âgées dépendantes en France : rôle de l'entourage et effets des politiques publiques*, PhD thesis, Paris-Dauphine University.

¹⁰ Ramos-Gorand M. (2015): *Accompagnement professionnel de la dépendance des personnes âgées : enjeux territoriaux en France métropolitaine*, PhD thesis, Paris-Est Créteil University.

3. Public support: Today's situation

	At home	Nursing home	Residential homes providing services
Care	Health insurance	Health insurance	Health insurance
Dependency ^a	APA type 1 ^b	APA type 2 ^c	APA type 1 ^b
Accommodation	APA (for the expenses of adapting accommodation)	ASH (means-tested and ancillary) ^d	ASH (means-tested and ancillary) ^d

Reading: APA (*Allocation personnalisée d'autonomie*): Long term care allowance ; ASH (*Aide sociale à l'hébergement*): Housing benefits.

Notes: ^a In addition to the APA, government funding is also provided in the form of exemptions from charges and tax reductions; ^b On the basis of expenditure, capped by level of GIR, user fees based on income and the total amount of the aid package; ^c On the basis of charges per level of GIR, user charge based on income; ^d Maintenance obligation and recovery from the estate on succession.

Source: Authors.

scheme established by the community socio-health team of the *département*. The personal amount of eligible expenditure is defined within a national limit, different for each GIR. The APA is not means tested but the level of financial contribution for which the claimant is responsible (the user fee) varies according to his financial resources. Unlike the specific dependence benefit which it has replaced, the APA is not recoverable from the person's estate.

In most institutions, the APA is paid directly to the organisation. The amount depends both on the institution's "dependency" prices and on the claimant's income. In addition to the medical package and the dependency rate, a third variable corresponds to accommodation costs. This is borne by the resident and the people liable for his maintenance obligations. In the event of insufficient income, housing benefit (ASH), recoverable from the person's estate, is paid by the local government.

Observation 3. In 2011, dependency represents an annual expenditure of around 41-45 billion euros, including 7-11 billion in informal assistance. Government expenditure (approximately 23 billion) focuses on health care and on the long term care allowance.

Monitoring of care services

Two factors justify active intervention by the public authorities in the domain of long-term health care: the protection of vulnerable individuals and the amount of public funding. This intervention occurs at two levels: in the authorisation to operate, which sets capacities for care provision (number of places, number of hours, geographical radius, etc.) and assumes the existence of internal and external monitoring of the quality of service; and in the providers' pricing structures. In practice, the providers are subject to one or more supervisory and price-setting bodies, depending on the nature of their activities:

- for health care, supervision is entrusted to regional Health agencies and financing to the Social Security health care department;

- for assistance with day-to-day activities, supervision is entrusted to local governments when assistance is given to vulnerable individuals and financing to local governments and to the *Caisse nationale de solidarité pour l'autonomie*, the French national funding agency for the elderly and handicapped;
- for accommodation, financing comes under local welfare support for the impoverished.

Within this structuring, several areas elude government regulation: private nurses' freedom to practise which gives rise to serious disparities between *départements*; the activities of "domestic workers" which, despite being financed by the APA, are only supervised by the Labour Code and the collective labour agreement; finally, the pricing of the EHPAD which are not eligible for welfare benefits (18% of institutions including 66% private profit-oriented EHPAD), the "accommodation" element of which is set independently. In addition, the multiplicity of regulators and funding schemes makes it difficult to implement an overall policy.

Government policy towards the dependent needs to reconcile aims which are to some extent contradictory: improve the quality of care, provide effective and fair coverage for the risk of dependency, and control public expenditure. Faced with this challenge, we propose four avenues which would improve both the quality of care and the efficiency of funding.

Widening the offer of care provision

For thirty years, the government has promoted home care provision. This strategy is officially justified by the wishes of the dependent elderly, but is also motivated by the high cost to government budgets of institutional care provision. It has led to a curbing of the capacity to provide accommodation in nursing homes and to the medicalisation of virtually all these institutions. Consequently, the "accommodation" element in their rates has significantly increased, whether they are regulated or independently set by the EHPAD. In 2011, more than one out of two residents had to pay outstanding costs which exceeded their resources.¹¹

¹¹ Fizzala A. (2016): "Dépendance des personnes âgées : qui paie quoi ? L'apport du modèle Autonomix", *Les Dossiers de la DREES*, no 1.

Accommodation in EHPAD today is saturated and concentrated. The overall occupancy rate (number of residents/number of beds) was 96.7% in 2011. According to the DREES, in 2007, 62% of the families of EHPAD residents estimated that they had waited for over a month between submitting their application and their relation's actual admission to the institution, and 16% had waited for over six months.¹²

This situation is a result both of the government's Malthusianism and of the small number of potential providers. The establishment, by the "Hospital, patients, health and territories" Act (2009), of a tendering process for the setting up of EHPAD has encouraged over-concentration in the sector. Compared to independent facilities, institution chains are often viewed by the decision-makers as being best placed to respond to tender specifications, primarily in terms of their financial soundness. In this context, institutions are subject to little (or no) pressure from competition; they are encouraged neither to improve the quality of their care provision nor to reduce their prices.¹³

The highly polarised nature of the provision of either home support services or nursing homes does not adequately respond to situations of intermediate dependence. Home care provision imposes a considerable need for availability on the part of the family, all the more so as the environment, often ill-adapted, accentuates restrictions in activity and increases the risk of future dependency aggravation. One thinks for example about the often decisive effect of falls.¹⁴

Observation 4. The provision of dependency care services is almost dichotomous, with nursing homes – a concentrated and saturated industry – essentially for the heavily dependent, and home support providing services in conditions which are sometimes detrimental.

This conclusion is not new and the ASV Act includes several measures destined both at reinforcing informal support and developing intermediate accommodation solutions, in particular through nursing homes.¹⁵ The efficiency of these measures is however conditional on the accessibility of fun-

ding and the attractiveness of this type of housing. The establishment, by law, of funding specific to these institutions (a package with funding of up to 40 million euros for 2017, which may be added to other benefits) is symptomatic of the difficulties to conceive a consistent funding in a system which makes a distinction between funding according to the type of care provision (home/institution) and the type of expenditure (health care/dependence/accommodation). In addition, the law bears witness to some hesitation over the type of housing itself, since for instance it allows for both facility plans oriented towards accommodating the dependent, and intergenerational plans which reserve some accommodation for young working people and for students. The question is therefore to find out whether assisted living accommodation could both respond to the needs of moderately dependent people and exploit a substantial demand for this type of housing offering benefits such as catering, laundry or supervision. It would therefore be useful, in guiding the development of this intermediary provision, to learn from the experiences of some other countries (the United Kingdom and Canada in particular) and to analyse more precisely the potential demand for this type of accommodation.

Recommendation 1. Ease the authorisation procedures for the creation of places in nursing homes. Analyse precisely the potential demand for different types of accommodation providing services.

Improving regulation and information to promote quality of care

In addition to the concentrated structure of institution-based care provision, the terms and conditions of government pricing do not supply sufficient incentives to raise the quality of care, whether in institutions or at home (box 2). For the area of the industry not subject to the setting of prices, the information available does not allow for a comparison of the services offered by different institutions, with the result that competition is essentially focused on pricing. In the United States as in Sweden, the availability of a government data-

¹² DREES (2011): « La vie en établissement d'hébergement pour personnes âgées du point de vue des résidents et de leurs proches », *Dossiers Solidarité et Santé*, no 18.

¹³ Research on the effect of competition on retirement home charges, based on British or American data, draws the conclusion that increased competition reduces charges. See Forder J. and A. Netten (2000): "The Price of Placements in Residential and Nursing Home Care: The Effects of Contracts and Competition", *Health Economics*, no 9, pp. 643-657; Gulley D. and R. Santerre (2007): "Market Structure Elements: The Case of California Nursing Homes", *Journal of Health Care Finance*, vol. 33, no 4, pp. 1-16. The impact of competition on quality is seldom observed. An American survey shows however that relaxing legal restrictions and cutting the percentage of available beds in retirement homes have a positive effect on quality of care, as measured by indicators such as the prevalence of bedsores, the degree of decline in cognitive capacity and the extent to which catheters are used. See Starkey K.B., R. Weech-Maldonado and V. Mor (2005): "Market Competition and Quality of Care in the Nursing Home Industry", *Journal of Health Care Finance*, vol. 32, no 1, pp. 67-81.

¹⁴ See, for example, Stillmunkés A., L. Goubin, S. Bismuth, F. Nourhashémi and S. Oustric (2015): "L'aménagement du domicile des personnes âgées est-il bénéfique ? Une revue systématique de la littérature", *Médecine*, vol. 11, no 1, pp. 17-20.

¹⁵ Being of social benefit, the charges for assisted-living accommodation are generally set by the government and residents may claim housing benefit. The most dependent residents, as well as those living in ordinary residences, may receive the APA (cf. table 3). On the other hand, assisted-living facilities (or retirement homes) are not regulated. These are luxury private residences aimed at the well-off (monthly responsibility for costs is between 3,000 and 4,000 euros). Residents may claim the APA for those living at home.

2. Pricing rates in EHPADs and for home care services

For residential homes for the dependent elderly (*établissements d'hébergement pour personnes âgées dépendantes*, EHPAD), rates are currently based on past budgets and on costs put forward by institutions.^a This frequently entails the annual renewal of previous budgets^b and an unjustifiable distribution of charges and therefore of quality of care. A proposed reform (art. L 314-2 of the Social care and family Code)^c makes provisions for the transition to a flat-rate charge per resident, with rates for health care and dependency packages determined by residents' degrees of dependency and their symptoms. The aim is to introduce competition by comparison, which would be liable to improve efficiency in performance and in the quality of care provision. However, the success of the reform presupposes that the additional costs linked to exogenous conditions (location, degree of dependence of residents, symptoms, etc.) might be precisely evaluated and included in the calculation of charges. In addition,

the gains in productivity would be limited, the quality of care in EHPAD being largely related to the amount of time devoted to patients and to the availability of staff. Finally, the reform itself would not improve quality of care without introducing contracts and the accurate monitoring of its various elements.^d

For home care services, budgetary constraints have already forced most local governments to implement the long-term setting of pricing rates. But rate-setting practices vary from one branch of local government to another. In some *départements*, the risk of deterioration in quality of care is increased by the calculation of rates which rely specifically on a set amount of qualified staff. In others, on the other hand, a double pricing system, linked to specific levels of care, counteracts this risk: hours worked by qualified staff on Sundays and bank holidays, for example, benefit from a higher rate of pay.

^a Institutions are nevertheless bound by pricing thresholds for the funding of health care and these are calculated according to the degree of dependence (mean weighted GIR) and to patient' symptoms (mean weighted PATHOS) (art. 63 of the LFSS for 2009).

^b Cour des Comptes (2014): *Le financement des établissements pour personnes âgées dépendantes et adultes handicapés*, Référé no 70592, 11 September.

^c The implementing decree has not been published (publication initially intended in September 2016).

^d The transition to flat-rate charges per person in retirement homes in the United States for the funding of Medicare in 1998 created a deterioration in quality of care and particularly in staff/resident ratios. See Konezka R.T., D. Yi, E.C. Norton and K.E. Kilpatrick (2004): "Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies", *Health Services Research*, vol. 39, no 3.

base concerning the quality of care in its institutions (staff/resident ratios, last inspection results, etc.) has made possible to raise it.¹⁶ In France, the ASV Act has reinforced transparency in pricing by obliging institutions to display their accommodation rates on a government website (www.pour-les-personnes-agees.gouv.fr including a simulation tool). These rates must include the minimum amount for basic services (administration, accommodation, catering, laundry, entertainment). However, this transparency is doesn't apply to any measure of quality of care.

To improve the quality of care provision, two further ways to regulate provision may be considered: rules and regulations, and information.

Rules and regulations

Following the examples of Germany, several Swiss cantons, and American states, it would be advisable to set minimum standards for EHPAD. These would appear to be indispen-

sible safeguards against a deterioration in quality of care, particularly in the event of a change to means-based pricing (*cf.* box 2). The staff/resident ratio is, in fact, the main determining factor in the quality of care provision: a shortage of staff leads to "excessive use of sleeping pills, the obliging of individuals who are not incontinent to wear pads, poor organisation of meals resulting in malnutrition, etc."¹⁷ and thus adversely affects the health of the residents. Significant correlations have been observed between low staff/resident ratios in terms of nursing staff and care assistants and the prevalence of bedsores, incontinence and residents' hospitalisation rates.¹⁸

By comparison with other OECD countries, the staff/resident ratio in residential homes for the elderly remains low in France.¹⁹ The implementation of the Old age support program (2007-2012) has allowed an increase in the number of professionals in EHPAD: the average staff/resident ratio has thus now risen from 5.7 FTE to ten residents in 2007, to 6.1 in 2011.²⁰ Progress in these staff/resident ratios should

¹⁶ Mukamel D.B. and W.D. Spector (2003): « Quality Report Cards and Nursing Home Quality », *The Gerontologist*, vol. 43, n° 2, pp. 58-66. Voir aussi Park J. et R. Werner (2011): "Changes in the Relationship between Nursing Home Financial Performance and Quality of Care under Public Reporting", *Health Economics*, no 20, pp. 783-801.

¹⁷ Dormont B. (2013): "Comment améliorer la prise en charge de la dépendance" in *5 crises : 11 nouvelles questions d'économie contemporaine*, Askenazy and Cohen (eds), Albin Michel.

¹⁸ See Spilsbury K., C. Hewitt, L. Stirk and C. Bowman (2011): "The Relationship between Nurse Staffing and Quality of Care in Nursing Homes: A Systematic Review", *International Journal of Nursing Studies*, vol. 48, no 6, pp. 732-750.

¹⁹ See Fujisawa R. and F. Colombo (2009): "The Long-Term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand", *OECD Health Working Papers*, no 44.

²⁰ DREES (2014) *op. cit.*



nevertheless be seen in the light of the rise in the level of dependency of the residents catered for and of their need for assistance; and the great disparity in staff/resident ratios, particularly depending on the institutions' status, needs to be emphasised.²¹

Information

In the United States, standardised data is gathered about the health state of each resident and provides information about the quality of dependency care provision and about health care. Experiments have been carried out on a local scale in some institutions in France but they have not been adopted nationally.²² The collection of information about the quality of care services (staff/resident ratio, health of residents, etc.) and its dissemination would allow institutions' pricing to be adjusted to suit the needs of residents, would encourage institutions to improve their quality of care when faced with a better-informed demand and would improve our understanding of the sources of quality of care in institutions. This information about quality of care could thus serve to greatly enhance the website www.pour-les-personnes-agees.gouv.fr.

Recommendation 2. Establish minimum standards for staff/resident ratios for EHPAD. Collect and disseminate information about the quality of care provision.

Reevaluating career developments and improving coordination to secure the loyalty of employees

Difficulties in recruiting and retaining staff partly account for the low staff/resident ratios observed in residential homes: 44.4% of EHPAD face recruitment problems. The situation is similar in the domain of home care where over 50% of recruiting agents state that they are experiencing problems, this rate reaching 65% for the recruitment of community care workers.²³ Staff departure rates are also very high in EHPAD, causing some institutions to be confronted frequent-

ly with circumstances in which they are under-staffed. This suggests that the assistance to dependent elderly industry remains unattractive. This is particularly clear in the case of home helps: contracts are largely part time,²⁴ employees in the industry –almost always women– attempt to compensate for by combining several jobs; an increased number of hours are worked in people's homes at the expense of time for coordination; hours are non-standard and variable; journeys are frequent and working hours are fragmented, going largely unrecognised by wage payment systems; and although the work is physically and emotionally highly demanding, employees mostly work alone. The conditions of work and pay –home helps' net average monthly wages were 790 euros in 2012–²⁵ do not bear comparison to other industries which require similar skills, like child care.²⁶

Conscious of the risks of a shortage of labour and concerned by improving the quality of care provision, the government has enhanced the professionalisation dynamic which has been under way for several years. The creation, in 2002, of the community care worker's certificate has put home helps at the same level of qualification and pay as care workers. Its validation through acquired experience became possible in 2003 in order to promote upward mobility for the industry's unqualified employees.²⁷ Horizontal mobility was also made easier with the creation, in January 2016, of the educational and social assistant's certificate: a fusion of the community care worker and the medical and psychological assistant's certificates that validates a more cross-cutting training course and widens the range of places of work and duties. The Program for long term care professions, launched in 2014, also allows for adaptation of the provision of initial and ongoing training by taking into greater consideration the specificities related to the loss of autonomy, in order to promote careers in gerontology.

However, a large number of employees find it difficult to benefit from these training strategies, particularly those with least job security such as the employees of private individuals.²⁸ In addition, such strategies can only be fully exploited if they are accompanied by the necessary funding. Currently employees are required to attend training without any noticeable effect on their wages or improvement in their working conditions, in order to balance the organisations' budgets.

²¹ The average staff/resident ratios are 5.3 FTEs to ten residents in private profit-making EHPAD, 5.6 in private non-profit-making EHPAD and 6.6 in state EHPAD in 2011. Yet private profit-making EHPAD currently cater for a greater number of seriously dependent residents (in GIR 1 and 2), DREES (2014), *op. cit.*

²² Cerase-Feurra V. (2001): "The Resident Assessment Instrument (RAI) : un outil d'évaluation de la qualité des soins de longue durée", *Gérontologie et Société*, n° 99, pp. 161-177.

²³ Observatoire de branche de l'aide à domicile (2012): *Aide à domicile*, National Report, April.

²⁴ According to the *Employment Survey*, over two thirds of home helps are part-time employees.

²⁵ CESE (2014).

²⁶ Nahon S. (2014): "Les salaires dans le secteur social et médico-social en 2011. Une comparaison entre les secteurs privé et public", *Études et Résultats*, no 879, DREES, April.

²⁷ 3 519 state qualifications in community care (DEAVS) and 2 676 VAE (validations through acquired experience) were awarded in 2011. Nahon S. (2013): "La formation aux professions sociales 2011", *Document de Travail de la DREES, Séries Statistiques*, no 175, January.

²⁸ Commissariat Général à la Stratégie et à la Prospective (CGSP) (2013): "Services à la personne : constats et enjeux", *L'Essentiel*, September.

Although a great deal of progress has been achieved in upgrading careers in gerontology, we need to go further in order to reduce staff turnaround and reduce recruitment problems. An emphasis on training is indispensable in the pursuit of professionalisation in the industry and in the fight against job insecurity of some community home health care workers, provided that such training is actually accessible. In addition, ongoing training may improve job satisfaction and, by this means, secure the loyalty of employees²⁹. The creation of future jobs in the industry, for which the Program for long term care professions also makes provision, may constitute an effective way to attract young people looking for work. The latter could then gain the qualifications they need to build themselves a career in the industry. However, these measures are not sufficient and the best-qualified professionals are still attracted to other industries. It would appear essential to improve the pay scale for careers in gerontology in order to make them more attractive, particularly in the home help industry, and to promote working patterns which help employees cope with the physical and emotional demands of these professions (provisions for the simultaneous employment of several employees in difficult cases, strengthen supervision, provisions for in-house team discussion and coordination time, etc.). Such measures would create significant additional demands on government funding even if gains in efficiency could be achieved through the implementation of a specific coordination of the various home support services.

Recommendation 3. Complement efforts to promote training by reevaluating elderly care career developments, and creating working patterns reducing the strenuousness of care professions and improving coordination of home support services.

A fresh look at funding

Shortfalls in current funding

Three poorly coordinated support schemes

Unlike Scandinavian systems, based on setting a limit on individual financial contributions and on government decisions in the type of care provision, the French system is organised so as to guarantee, in theory, freedom of choice for the dependent elderly. But in practice the existence of different support schemes for health care, assistance and accommodation largely conditions this choice and consequently impairs the efficiency and equity of the system.

Financing the costs of dependency is based on three different support schemes, according to the type of expenditure:

- universal and independent of income for health care;
- universal but decreasing according to income for dependency *stricto sensu*;
- means-tested, ancillary to maintenance obligations, the accommodation element being recoverable from the person's estate.

The coordination between these three schemes poses a problem when the risk covered –the loss of autonomy– results in simultaneous additional expenditure in terms of health care, dependency *stricto sensu* and accommodation: in its current form, additional expenditure in terms of accommodation is only mutualised for those whose income is inadequate to fund it (*via* the ASH), even though this additional expenditure is the result of the development of the dependency and is not due to preferences in terms of accommodation. In addition, the ASH is a supplement, unlike the APA, and is characterised by a great lack of take-up. The system results, *in fine*, in an affordability ratio (i.e. the dependent individuals' financial contribution in proportion to their income) which is higher in institutions than at home for households with modest incomes, in contrast to wealthier households. The current system thus does not guarantee the most suitable choice of accommodation for the dependent individual; and the growth in the provision of residential accommodation for individuals or couples with a moderate level of dependency is curbed by the structure of state provision itself.

Limited uptake of private insurance

The market of private insurance against the risk of dependency is relatively well developed in France and in the United States, compared with other advanced economies. However, with around 10-15% of the population covered by private contracts, this is nowhere near the reported level of health risk coverage.

There have been many attempts to explain this “failure in the market” without reaching a consensus. One section of the literature highlights the effect of alternatives provided by family or state aid, which seem to reduce the demand for dependency insurance. Another focuses instead on information asymmetries and on the phenomena of adverse selection: individuals who are aware of the risk are often elderly and possess private information on their state of health, which results in insurers demanding high insurance premiums in order to protect themselves from a variety of “bad risks”. Others, finally, emphasise the difficulty experienced by insurers in determining the level of actuarial premiums, given the changing definitions of the prevalence and costs of dependency. This has resulted in French insurers mainly proposing flat-rate annuity contracts (where the amount may depend on the level of dependency), which do not provide any real cover against the risk of dependency.

²⁹ See Castle N., J. Engberg, R. Anderson and A. Men (2007): “Job Satisfaction of Nurse Aides in Nursing Homes: Intent to Leave and Turnover”, *The Gerontologist*, vol. 47, no 2, pp. 193-204.

Poor use of dependent individuals' household assets

According to the 2010 INSEE survey of assets, 75% of couples over 70 own their main residence. This “dormant capital” has given rise to many surveys which emphasise its potential for financing the large amount of outstanding costs in the payment of EHPAD accommodation or when adapting private accommodation for a moderate level of dependency.³⁰ For several years, the government has tried to promote the monetisation of these assets, with limited success to date (box 3).

The options for reform

The first option for the reform of funding for dependency would retain the three current government funding schemes (health care/dependency/accommodation) but would structure them differently so as to encourage greater efficiency in the choice of care provision, without leaning too heavily on government budgets. A more ambitious alternative –since it differs more widely from the current system– would be to impose obligatory, mutualised dependency insurance coverage for cases of serious dependency.

Option 1: Promoting greater efficiency in the choice of care provision

In order to improve the efficiency of government funding without changing its current structure, we propose three measures.

Basing state funding on the least expensive type of care provision given individual levels of dependency

The amount of state aid would be the same, whichever type of care provision was selected, referring solely to a basic set of guidelines for care provision that have been stipulated by an evaluation team. Each person would then have the right to depart from the evaluators' stipulations but would be responsible for the possible additional expense. The implementation of such a system would presuppose entrusting experts and professionals with the establishing of standards of quality of care and a pricing reference; this would be complicated but possible, in our opinion, for example under the aegis of the *Caisse nationale de solidarité pour l'autonomie*, the French national funding agency for the elderly and handicapped. Choices outlined in the care provision guidelines would need to take into account all the additional economic costs of each possible type of care provision, and not state expenditure alone. In terms of home care provision, this raises the sensitive question of the evaluation of the high cost of informal support, i.e. developing a support plan that does not have “additional” implications for families. This is nonetheless a prerequisite so that home care provisions do not automatically, and deceptively, appear to be the least expensive option³¹

³⁰ Mésonnier J-S. (2004): “Crédit hypothécaire et soutien à la consommation : quelles leçons tirer du modèle anglo-saxon ? », *Bulletin de la Banque de France*, no 132.

³¹ Bouget D. and R. Tartarin, M. Frossard, P. Tripiet and R. Meudec (1990): *Le prix de la dépendance : comparaison des dépenses des personnes âgées selon leur mode d'hébergement*, CNAVTS (ed.), La Documentation française. Hebert R., N. Dubuc and M. Buteau (1997): “Services requis par les personnes âgées en perte d'autonomie. Évaluation clinique et estimation des coûts selon le milieu de vie”, *Étude et Analyse*, no 33, Ministère de la Santé et des Services Sociaux (Montréal).

3. Three schemes for the monetisation of property assets

The life annuity (occupied), practised by mutual agreement: only the bare ownership (not the usufruct) is sold for capital (known as a “down payment”) and possibly index-linked pensions. Today, the life annuity market is sluggish, with around 5,000 sales per year. It is, in particular, very unbalanced with one buyer for every ten sellers and a sale taking over 18 months from start to finish. The balance of power is therefore clearly weighted in favour of the buyer. Thus life annuities without pensions (full down payment), which sellers often prefer, and modest properties are relinquished.

The mutualised life annuity (or viage): the buyer is a registered institution subject to regulations or even to social imperatives. His diverse portfolio allows him a double mutualisation: on the date of death of the sellers and on the sale price of the property. The *Caisse des dépôts et consignations* recently launched a life annuity fund, Certivia, aimed at the over-70s, in collaboration with several institutional investors. There are still a number of obstacles for potential sellers: the risk of net loss in the case of premature death (particularly if the pensions are sizeable); descendants being dispossessed of a property legacy; a limited yield from the transaction due to the mortality table used, that of life-annuitants, which raises the value of the property; the loss of ownership of the property. The mutualised life annuity may provide a useful supplement, but it does not adequately cover the costs associated with dependency.

The reverse mortgage instituted in France in 2006 using the English reverse mortgage as its model: a loan secured on property, contracted by elderly home-owners who remain in their home, retain its ownership (without alienation of the property) and receive capital and possibly annuities until their deaths. This capital and these annuities are repaid to the bank on their death, when the property is sold (or repurchased by their descendants): the longer the person lives, the greater the debt and the smaller the descendants' legacy will be. The reverse mortgage solves many of the problems inherent in the life annuity but it suffers from two major handicaps. On one hand, it may appear “antifamily”: the inheritance becomes aleatory, reduced by a debt which rapidly increases the longer the parents live. On the other hand, the interest rates charged are very high (8%): the bank covers itself against the risk of an accumulated debt exceeding the value of the property on succession. As such, the product has had only limited success: current stock is only 6,000 to 7,000 reverse mortgages, mainly at *Crédit foncier*.

and so that state aid is not any less generous when families are involved in day-to-day support. In addition, this principle presupposes that the ready availability of the care provision specified would be guaranteed across the country.

Extending the APA to fund the additional costs of accommodation attributable to dependency

We propose replacing the current system, which combines APA and ASH, with one sole benefit, an “extended APA” which would cover all the costs of dependency except health care, including the additional costs of accommodation due to dependency (table 4). At home, these additional costs –which mainly correspond to the costs of adapting accommodation– already come under APA funding. In residential institutions (with or without nursing services), they correspond to the additional accommodation costs incurred, when compared to standard cost of living indicators.³² The amount for which dependent individuals would therefore be responsible would comprise a fixed amount for accommodation costs and a proportion, increasing with income, of the additional accommodation costs and dependency *stricto sensu* related expenses (graph). This system would have several advantages: the need for legal recourse to people liable for maintenance obligations would be eliminated; territorial inequalities in access to state aid would be reduced; it could easily be applied to any new form of care provision;³³ and a greater impartiality in state aid would be secured when facing decisions concerning the choice of care provision for individuals according to their level of income and their family situation. However, the elimination of the principle of subsidiarity is not insignificant for government budgets. The risk of an increase in the demand for EHPAD care provision, linked to the harmonisation of government funding, would be contained by the first measure proposed, since government funding would only be granted on the basis of the cost of EHPAD care provision if it were to be deemed the most efficient. On the other hand, due to the low rate of take-up of the ASH, the option of an extended APA is liable to represent an additional cost to government funding (a precise estimate of which would necessitate an in-depth study taking into account variations in behaviour), as well as an improved provision of care.

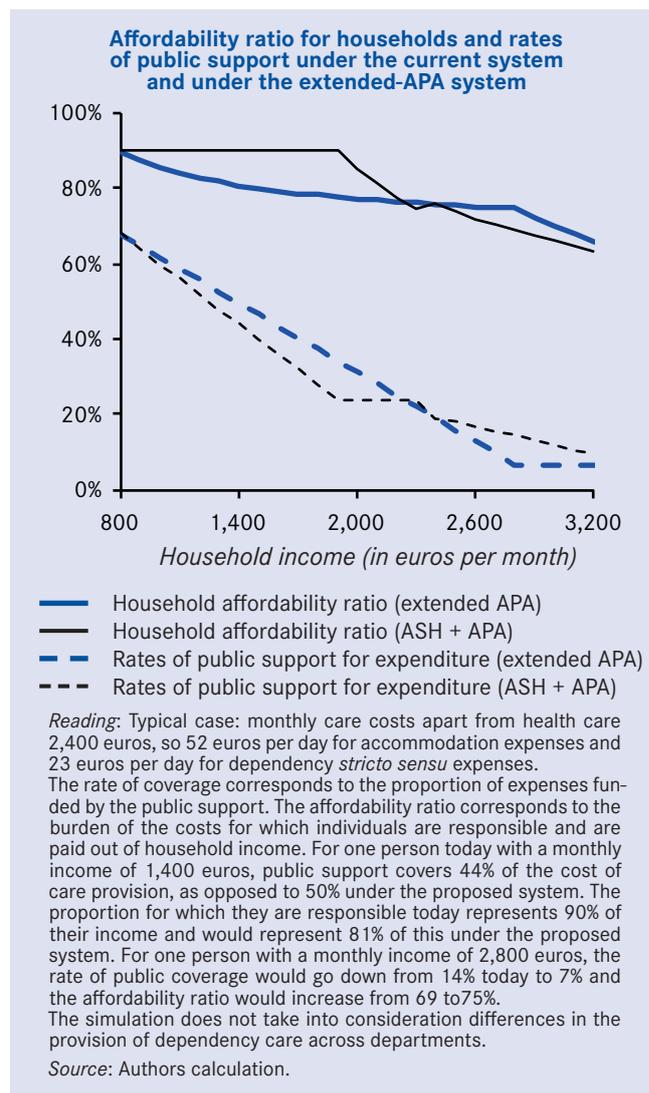
Establishing a dependency loan

The reform in state aid would not eliminate the obligation to pay potentially high proportions of costs, especially since an improvement in quality of care would entail an increase in the provision of care services. To address this, we propose, in addition, the establishment of a dependency loan so as to facilitate the use of household property assets.³⁴ The dependency loan would aim at remedying the two main problems concerning standard reverse mortgages: their “anti-family” nature and their high interest rates. It could only become widespread on two conditions: that sons and/or daughters participate in the choice of an arrangement which would seem acceptable to themselves, so that in no way they consider themselves dispossessed; and that the life expect-

4. Public support after reform

	At home	Nursing home	Residential homes providing services
Care	Health insurance	Health insurance	Health insurance
Dependency	Extended APA ^a	Extended APA ^a	Extended APA ^a
Accommodation	Extended APA ^a	Extended APA ^a	Extended APA ^a

Note: ^a Depending on the level of GIR, and decreasing with income.
Source: Authors.



tancy of the borrower is limited (this diminishes the risk of the accumulated debt exceeding the sale price of the property and allows, on its recovery by the bank, the advantage of lower rates). The dependency loan would only be granted to a person whose dependency had been confirmed and certified

³² For example, 90% of the current amount of income support for the elderly (being 801 euros per month on 1st June 2016) or a threshold set according to housing benefit limits.

³³ For the new types of shared accommodation mentioned previously, the additional costs in terms of rent would logically come within the scope of this extended APA.

³⁴ See Masson A. (2015): “L’épargnant propriétaire face à ses vieux jours”, *Revue Française d’Économie*, no 30, pp. 129-177.

(GIR 1 to 3), for the purpose of funding the high cost of their care, whether the borrower wishes to remain at home or move into a nursing home: in the first case, his life expectancy, much shorter and easier to monitor, would allow the bank to lower its rates to 4% (according to experts in the industry); in the second, the loan could serve as a bridging loan before the sale of the property by the family, in accordance with a deadline set in advance and authorising even lower interest rates. The product would take into consideration the fact that the borrower would usually only partly own a property which he shares with his spouse or his sons or daughters: the dependent individuals being no longer really able to decide for themselves, the (difficult) decision to take out a loan would in general be shared within the family –which would be further justified by the fact that ownership of the property is itself often shared.³⁵ This dependency loan would be reversionary, allowing the family to bring forward the reimbursement of the accumulated debt when the elderly relative dies (or moves into an EPHAD) if they wish to retain the property. It should be noted that, in the case of individuals endowed with property assets but whose income is modest, the dependency loan would resemble the current ASH, without involving any recourse to people liable for maintenance obligations during the lifetime of the beneficiary.

Recommendation 4a. Ground public aid in the least expensive type of care provision taking into consideration the level of dependency of the individual. Suppress Housing Benefit (ASH) and extend the Long term care allowance (APA) to cover additional accommodation costs. Design a dependency loan, available in cases of serious and certified dependency.

Option 2: Compulsory insurance against the risk of serious dependency

Cases of heavy dependency (GIR 1, 2 and 3) are not very common or long-lasting, but come with large outstanding costs.

Insurance coverage would give great benefits in terms of general well-being. And yet, as we have seen, the market does not manage, for various reasons, to provide this insurance. An ambitious option would therefore consist in introducing a two-tiered scheme:

- for the risk of heavy dependency: an obligatory, mutualised insurance coverage for the entire population;
- in circumstances where dependency is mild, means-tested state aid.

The refocusing of budgets which are at present allocated to funding the APA would allow the introduction of an insurance against the risk of heavy dependency covering largely all the additional costs linked to dependency (health care, dependence *stricto sensu* and accommodation). This could conceivably be a public insurance such as a new sector of Social Security, or obligatory, mutualised insurance coverage based on a contract defined by the government, the management of which would be entrusted to private insurance companies, where competition would be regulated.

The risk of mild dependency does not really pose a problem for low-income households; a support scheme would be justified, but not obligatory and universal insurance. On the other hand, heavy dependency affects the entire population, with the potential for catastrophe as when hospitalisation occurs under state health coverage.

Recommendation 4b. Introduce an obligatory insurance with mutualisation for the risk of heavy dependency.

Adequate coverage against the risk of dependency –particularly heavy dependency– is a major issue which concerns the well-being of individuals during their lifetimes. Improving coverage will be expensive, but room for manoeuvre does exist for improving the efficiency of the system and making better use of private funding. ●

³⁵ If the dependent borrower has a surviving spouse, the loan may only apply to a secondary residence or property for rental, unless the latter possesses the means to leave the joint property on the death of the borrower. See Bonnet C., S. Juin and A. Laferrère (2016): *Financing Long-Term Care Through Housing In Europe*, Mimeo.



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