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SECTION J

POOLING PUBLIC AND PRIVATE FUNDS IN THE PATIENT'S INTEREST:THE CASE FOR LONG-TERM CARE INSURANCE

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Abstract—Although the extent of medical care in France may be thought adequate, the same does not apply to the social medicine sector. The Assurance-maladie paid 87.7% of hospital health expenditure in 1994, whereas direct funding of home assistance amounted to only 9%. In contrast, a recent Legos study (Bungener M. *et al.* Le bilan économique et financier du secteur médico social, Université de Paris IX, Legos, Janvier 1994) [1] estimated that home assistance costs represent 41–50% of medical–social expenditure. When people are unable to manage because of the high costs of their invalidity, the social security system comes to their assistance, although only under Draconian conditions involving compulsory "family support commitments" and the state's claim on the inheritance of the beneficiary (total costs for hospital admission and boarding and the dual limits of 1000F liabilities and 250,000F net assets for home assistance). The elderly well appreciate the severity of this problem and are deeply distressed by the thought of dependency. Many, however, live under the illusion that the social security system or, to a lesser extent, the mutual funds will come to their assistance, although the problems involved lie partly outside their remits. We therefore need to design new systems to allow the elderly to finance their costs should they become dependant. Copyright © 1996 Published by Elsevier Science Ltd

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THE PEOPLE INVOLVED

There are two target populations: the elderly themselves, and their children and near relatives.

The elderly

The elderly become involved with the problem at various stages. Theoretically, it is very much to their benefit to subscribe to "invalidity-dependency" plans during their active life through group contracts, which may be underwritten by insurance companies. Contribution would then be low, the people involved young and the contract collective in nature.

In fact, as the American experience tends to show, it is likely that companies will not accept the increased additional cost and that employees themselves will not appreciate by the problem at that stage in their life.

Invalidity contracts are, therefore, very likely to be underwritten individually when beginning retirement or in the final years of employment.

The children

The children may finance a plan themselves for their parents' benefit if they have the means to do so, in order to avoid having to fulfil their "family support commitments" and see the family inheritance used up.

MEANS OF FINANCING

Two means exist: distribution and capitalization.

Distribution

The distribution method involves creating a mutual fund from the subscribers' contributions and mobilizing the subscriptions of those who are not dependant in favour of the less fortunate. The financial risk associated with dependency is, therefore, spread throughout all subscribers. The payments depend on falling into the position of becoming incapacitated-dependant. If this does not occur, the contributions are lost.

Capitalization

In this method, an individual finances to a large extent her/himself, and s/he underwrites the guarantees; the amount depends on the length and size of contributions and the quality of care provided by the assurer.

In the deferred *life annuity system*, available resources at end of contributing are independent of the needs of the insured. The annuity is automatically paid from an age determined by the contract, regardless of whether or not the individual is dependent. The practical features of the contract, however, may restrict the amount by setting pre-established limits to payments if a risk outcome develops. The Assurances de Groupe de Paris (AGP), for example, has a novel combination of a "time-limited system" where funds built up may be paid if dependency develops until a date set in the contract, and a "deferred life annuity" that assumes

payment of an annuity from a given date until the end of the subscriber's life, regardless of his state of health.

In an "immediate whole of life" system, the insurer pays the pension to the beneficiary if invalidity-dependency develops, regardless of when this occurs, until death if the plan is continued. This is of course a capitalization system with technical reserves, although the risk is widely shared as in the case above. Indeed, no payment is made and premia are retained by the company covering the risk if the elderly person remains healthy.

"Distribution insurance" and "capitalization insurance" should in principle be used in *well-defined situations*: distribution insurance when the financial risk is high but the event rate rare (severe incapacity, institutionalization); capitalization insurance when the financial risk is lower and the risk of use is higher (mild incapacity, home care).

GUARANTEES

Two types of contract may be envisaged depending on whether we are looking at life assurance or sickness/injury insurance.

Life insurance

This guarantees payment of a sum set in advance payable per month, per quarter or per year. Two such types of plan exist in France today: the "old age" plan from the Assurances du Groupe de Paris (AGP), and the "permanent total invalidity with dependency" plan from the Association Générale des Retraites par Répartition (AGRR).

The AGP plan. The "old age" contract from the AGP is a combination of savings (capitalization) and insurance, which according to its advertisements provides anyone over the age of 50 with three guarantees plus:

- "old age" annuity payment of deferred life annuity to the assured person regardless of his state of health from a set age between 75 and 85 as selected by the subscriber;
- early payment of the annuity if autonomy is lost before a set date, if the condition of the insured person requires a third party to be present;
- payment of a capital sum on the death of the assured to a chosen beneficiary. The sum is at least one-quarter year's annuity payment; and
- premium relief if payment is made on the policy.

The costs are as follows:

- to subscribe at the age of 50 and receive an annual pension of 120,000F from the age of 75 the assured must pay a single lump sum of 360,682F or an annual premium of 36,707F for 20 years; and
- to receive the same pension from the age of 80 the assured must pay a single lump sum of 203,086F or an annual premium of 24,738F for 20 years.

The AGRR contingency plan. This is a "whole life" assurance that pays a quarterly pension whilst the assured remains alive with no time limit, if the assured becomes permanently and completely incapacitated and requires the constant assistance of a third party for at least three months or requires three of the four normal acts of daily living to be performed for him, as is needed in advanced senile dementia.

Current premia vary from 44F per month for the minimum option at 50 years of age, which provides for 6000F per quarter, to 339F per month for the maximum option at the age of 70 providing 18,000F per quarter.

Comparison of the two plans.* The AGRR programme is risk only insurance, whereas the AGP plan offers a deferred guaranteed payment.

Premia for the AGRR plan change with time depending on the actual value of pension. In the AGP plan, however, the interim premia are constant and depend simply on the age of the assured at the time the contract is taken out.

In the AGRR contract, if the assured does not pay his premium he loses all of his investment, whereas in the AGP programme the lifetime pension is reduced pro rata.

Comparison with the United States. As in the United States, the two French plans are indemnity plans, which do not cover all costs that may be required by elderly people if they become dependant. The assured is endeavouring to limit his risk.

As with its American counterparts, the AGRR assumes a three month invalidity period before the guarantee is fulfilled as a safeguard clause to exclude temporary illness and limit risk. The risk assured is well defined. In contrast, and also in contrast to the American plans, the guarantee provided is not restricted in time and may be paid either to cover institution lodging costs or costs of maintenance at home.

Sickness/injury insurance

The idea is to provide similar guarantees to those people in the health sector, i.e. to indemnify the assured for the financial risks s/he may be exposed to. The Braun report [2] quotes the need to establish mechanisms to offer these guarantees and appears implicitly to refer to this type of plan.

The advantages of these plans are clear: they are better suited to the needs of the elderly, provide easy access to organizations and solvency.

The risks, however, are enormous. Although medical needs are relatively well circumscribed, social needs are still poorly defined. It is likely that a huge

*This article was written before the Caisse Nationale de Prévoyance (CNP) and Union des Assurances de Paris (UAP) plans were announced; their contents could therefore not be assessed in this article.

"moral change" may occur as families tend to distance themselves, secured by the existence of the assurers themselves. Premia, consequently, will rise and will continue to underwrite poor risk. It is, therefore, unfortunately likely that an *anti-selection* vicious circle will establish.

The Braun report [2], in its initial version, attempted to solve these two problems of long-term insurance—moral risk and anti-selection—by making this compulsory at the time pension rights are attained. In its definitive version, it limits itself to institutional "autonomy insurance" without stating whether this should be voluntary or compulsory.

In the case of voluntary insurance a product should be defined that fulfil the clientele's expectations without exposing the assurers to unreasonable risk if they market such plans.

What are these expectations? Subscribers usually reject the thought of having to go into a retirement home; their main wish is to stay at home, i.e. not be removed from their own environment.

In the market, it would, therefore, be unrealistic to offer them a policy where the benefits are restricted to care in an institution, even if this type of contract is preferred by the assurer who sees in it a way of limiting his/her risk.

Large scale sales of "actual cost-dependency insurance" contracts must, therefore, include home care costs. The moral risk thus becomes enormous, and the following safeguards may be considered:

- exemptions or patient contributions;
- a ceiling on home care payments that is set at or below those of management in an institution; and
- instituting a control system to limit access to funding.

Either way, such a "*home-dependency insurance*" system cannot be designed without being closely linked to medical expenditure. This, however, comes into the framework of an integrated cost assurance system.

THE THIRD APPROACH: ASSISTANCE ASSURANCE

According to Barroux and Dessal's definition, assistance assurance "does not retrospectively reimburse a sum of money for a service paid, rather, it provides a service" [3]. Its principal, therefore, relies on establishing an entire management system providing considerable flexibility. We must not delude ourselves, however; we will not change present structures overnight. They are part of a network of statutory, financial and personal relationships that maintain the status quo. Any proposition to integrate these bodies in one act would be destined for failure. It would be better to ignore the single economic basis and merge the finance mechanisms of the different competing care and assistance organizations. This type of system would be based on the following six rules of action.

Offer a total management system

To improve the efficacy of the system a single line of approach is needed; the system must decompartmentalize the services provided, the populations managed, the finances and risks. It is not enough to call for coordination; we have to offer an organizational structure that enables this to occur.

Coordination does not happen on its own or by simple mutual adjustment. It requires an organizational and decisional structure to be established, lead by the "medical director" and the "social coordinator".

The medical director coordinates all diagnostic and treatment decisions including admission to hospital. He is the gatekeeper to continuity of care.

The social coordinator examines the family setting and is responsible for managing the patient's direction at the end of his life. The social coordinator will identify if a situation of distress is present and will plan for assistance to be provided in day-to-day living and will evaluate the basis of placement policies.

Locate new finances

Henrard [4] states that the health sector receives five times more money than the social sector. Expenditure dedicated to home care services is less than half of that involved in admission to an institution. This dual asymmetry of the flow of money tends to push the ageing process towards medicalization leading to hopsital admission:

> 38% of 27000 patients admitted to hospital for more than twenty days into short stay units have their hospital stay extended for no good reason. 27% of people of admitted to institutions should not have been there and 40% of patients admitted to psychiatric hospitals are not discharged from these institutions [4].

To avoid diverting the health care system from its vocation to care, we have to develop neighbourhood services and intermediate care facilities that help to keep the elderly in surroundings to which they are accustomed.

The Braun report [2], which recognizes the "indisputable" nature of these needs asks the major question: who is going to pay? Neither the Assurance-maladie, departmental budgets nor social funds can face this vast increase in demand alone. We can see new private insurance structures interlinking with public finances. Development of this type of system poses two problems: the type of help provided by the paying bodies and the controls on distribution.

Create inclusive management

The respective contributions of each financial body may be found from what each pays out per subscriber.

Each body knows of the average amount and expenditure either reimbursed or paid per beneficiary. Each also knows the incidence of those affected, i.e.

the proportion of beneficiaries compared to the whole population that they manage. The product of these two terms gives the mean expenditure per person protected. Instead of this amount being paid retrospectively, this sum can of course be paid in advance, irrespective of which body may make these calculations. This process quite clearly happens with the Assurance-maladie, mutual funds and insurance companies.

In legal terms, the Bérégovoy law (19 January 1983, Article 17 and decrees relating to its application dated 22 June 1984) offers a legal framework for this type of indemnity in the health sector. This has been taken up by the Code de Sécurité Sociale, in Articles R162-42 and subsequent, which stipulates that agreements may be made between health insurance bodies and individuals or public or private bodies to carry out experiments in the social medicine sector. Medical expenditure resulting from such activity may be covered by the state funding departments (*caisses*).

In terms of local communities, Article 33 of the law (dated 19 July 1983) and Article 137 of the new Code de la Famille offered the same facilities in social terms. The department has the right [5] to devolve by agreement part of their obligations in social medicine to a community. The *conseil général*, who must ensure that the corresponding costs are financed, may do this via a lump sum payment. The commune may itself cede responsibilities devolved to it and the financial means for achieving these responsibilities back to the Centre Communal d'Action Sociale (CCAS).

For home assistance, the principle of reimbursing services provided remains out of reach, although activity contracts that were introduced in 1986 [6] explicitly define a provisional number of hours allocated for an anticipated volume of expenditure. These contingencies or volumes may be easily changed depending on the characteristics of the citizens who are helped by the services; this differentiation already operates at a national level. The administrative committee of the CNAV decided in October 1985 to count all people aged 75 years old and above who were resident within the regions when calculating the funds to be allocated to home assistance awarded from the regional Assurances-maladie.

Inclusive management comes directly from the recommendations of the Comité des Sages [7], although they offered this only as a footnote. "The allocation to each affiliated person", which would need to be observed when expenditure is to be rationalized, inevitably leads to calculation of *actuarial costs* for each class of risk.

In practice, the method must be refined and equivalent groups must be determined for age, sex and level of dependency. Experience of the American Medicare [8] insurance panel demonstrates that the final criterion must be to include the needs of the elderly and be used as a basis for determining the sums required. Information provided by this panel clearly shows that people who have lost their autonomy are more expensive than the moderately dependant and independent.

The increase in cost due to loss of autonomy is high and remains at a higher level for longer.

Medical expenditure on an elderly dependant person still receiving medical attention in a nursing home is twice as high as for similar pensioners resident in the same places.

The number of days spent in hospital by severely dependant elderly people in the two years before and the two years after the time they become incapacitated is 1.75–3 times higher than for *active* subjects.

In death, the differences in medical usage disappear, although the financial risk continues. An elderly person, whether dependant or not, who dies in a given year, consumes four times more days of hospital care than a person of the same age in stable medical health. The mortality rate in the highly dependant elderly is five times higher than in active subjects.

These findings are confirmed by the Haute-Normandie [9] survey; the incapacity level over three years is the strongest predictor of mortality, apart from age itself (see [9], p. 35).

Together, these findings demonstrate that dependency is undeniably a factor that increases costs [10]. To avoid institutions specializing in recruiting healthy elderly, it is essential to adjust annual health payments according to the level or degree to which autonomy is lost for the subjects who are looked after.

Consolidate resources

Devolution of budgets that are adjusted to take account of age, sex and the level of dependency and are paid prospectively to the health and assistance teams avoids problems due to differences in financing and limits cross-charging. Contributions from the different financial organizations involved are determined by the actual amount of expenditure per head and are distributed pro rata between them according to the number of people they care for. Their respective involvement is combined into an aid and health care team and managed in a multifaceted global financial structure.

A triple financial network must be organized around a "supporting institution" [11]. If the income of an individual with national insurance falls below the *Aide sociale* intervention threshold, the Assurance-maladie pays an annual sum (*forfeit annuel de santé*) (FAS) to the network for the person's management [12]. The additional sum is paid in advance by the *Aide sociale* system either as assistance for the elderly or as *Aide medicale*. All costs of health care and social support are borne by the community, national or regional financial bodies.

If the income of the insured is higher than the *Aide sociale* threshold but lower than the pension structure intervention threshold, the Assurance-maladie pays the FAS, and the costs of home assistance are borne by money from *Action sanitaire et sociale* by class of risk, within the limit of their resources. The potential user of the system pays that fraction of the expenditure above the total amount covered by the organization, all other sources of financing combined. He pays this in advance, however, in the form of a monthly sum which is identical in amount regardless of the body to which he is affiliated. This "standardized contribution scale" creates local consistency that removes differences due to the different budgets of national bodies. Public and private finances are linked together in the support teams. The contribution from insurance is only marginal, however, and only the health or social patient contribution is covered by the mutual assurance funds.

When the elderly person has taken out an "assistance assurance" policy, the health and assistance organization and insurer pool resources to optimize management of the risk. The health care and assistance body:

- receives the annual health budget paid by the Sécurité Sociale;
- delivers care and provides home support and accommodation;
- provides services that may be required by the elderly if they lose their independence; and
- distributes the sum from the corresponding insurance and receives some of the premium contributions.

The insurer plays the conventional role of facilitator, i.e. managing network contracts and reinsuring part of the risk. The system functions on a strict distribution basis; premia collected during a year are redistributed in the same period as payments.

This three level integration links the national and departmental, public and private finances and inter-reconciles the "existence of a dual health and social sector which would appear to be difficult to rescind and requires it to think in terms of combined structures". The introduction of participation from users into levels two and three, the principle of *économicité*, brings in user choice; genuine competition may, therefore, develop between the management organization such that the service providers may lose their clients if their quality of service deteriorates or contribution costs are too high. In order to keep their users, health care and assistance teams are encouraged to improve the quality of service provided and control costs.

Make the users responsible

The priority in effectively allocating resources is to define rules of action that encourage the people involved to take on their own responsibilities. The financial risks of hospital admission, boarding in retirement homes, outpatient care and home assistance have to be shared by all users, and financial incentives must be introduced. A contingency reserve must be established for unexpected deficits.

Associate the different promoters with the overall results of the experiment

Sharing results [14, 15] between the support organization and its financiers enables to cost of the experiment in the market to be calculated whilst still providing the essential safety net to guarantee continuity of care. The following arrangement, for example, could be used: if the end of year surplus does not exceed 1% of the planned budget for the organization, no payment is made. All benefits are distributed between the Assurance-maladie, the departments and pension organizations pro rata to their respective involvement. If the excess is 1–3% of the sums allocated to in the initial budget, the organization receives 25% of the savings to which it has contributed. Above 3%, 50% of the budget excess is allocated.

This type of arrangement encourages the financiers to participate in the experiment as they reduce their costs compared to the conventional management system with the result that they are prioritized to receive their benefits. This introduces a strong incentive towards *économicité*, and the organization has to make significant budget savings in order to receive part of these.

A similar type of arrangement could be used to share losses.

A NEW PARTNER

The role of the Centres Communaux d'Action Sociale in the system

Although the development of dependency-assurance plans appears essential, international experience has shown that it is difficult to achieve these voluntarily. First, the elderly are poorly informed about the gravity of the problem that they face, and second, they mistrust the assurers. The proposition of compulsory insurance initially proposed by Braun seems to have little chance of success in a setting where we are trying to reduce compulsory contributions.

An intermediate solution involves using the CCAS. This has three purposes:

- *to inform the elderly* and encourage them to protect themselves by taking out the essential contracts whilst there is still time;
- *to defend their interests* and thereby secure them by making group retirement contracts with the companies; and
- *by making privileged agreements* with service or care providers (low-price contracts or overlooking charges).

The strategy for providing care in each scenario

Personal assurance. The association of the roles between the service providers and insuring bodies is quite clear. Service providers retain their independence and it is in their interest to work with all companies or mutual funds to increase the number of potential users covered by this type of contract.

Conversely, the guarantee they provide does not cover all costs of lodging or home assistance, and demand is incompletely met.

Sickness and injury assurance. The assurers are extremely reticent to introduce this type of contract as it has not come to terms with the factors that define expenditure and the premia required. The only possibility would, therefore, appear to be a privileged agreement with an assurance company in which, as a minimum, a cost reduction policy would be agreed.

Working with one company, however, may restrict the market. It would be better to work with the CCAS to place policies.

Assistance assurance. This enables optimal support for of the assured and is also the most logical in terms of use of resource. It will only have full effect if the Sécurité Sociale contributes an annual health budget.

At present, a management structure that enables Sécurité Sociale to avoid costs of unnecessary hospital admission does not reap the benefits of its efforts as it cannot use savings made to finance new developments (warden care, transport, etc.). To broaden the range of services it provides it can only use contributions from the elderly themselves, or grants. Creating a multifaceted financial system through a coordinated medicalo–social network experiment (*réseaux médico–sociaux coordonnés*) (RMSC) will allow it to receive part of the savings it makes and would be a step forward in matching needs to the means available [16].

Regardless of the formula we use, we need to collate the information that is essential to the system being developed and that is currently lacking, which is:

- the prevalence and incidence of severe incapacity nationally, by age of occurrence and invalidity;
- institutionalization rates for those more than 65 years of age, their age of entry and level of dependency;
- life expectancy for institutionalized people;
- probable cost of proposed guarantees; and
- mean delay for the payment of contributions.

A dialogue with assurers is necessary to continue in this field, and health care and assistance teams have to define strategies they want to adopt for private insurance companies.

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