

Ageing policies – access to services in different Member States

Annex II - Country study on France



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Abstract

The study provides an overview of the most recent developments with regards to ageing policies and access to services by older people in France. It focuses on six areas: active ageing, economic participation, social participation, health care, long-term care, and supportive environments. The study includes examples of best practices regarding access to services and assesses the impact of COVID-19 pandemic on the well-being of older people.

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LIST OF ABBREVIATIONS

APA	Allocation Personnalisée d'Autonomie (Personalised Autonomy Allowance)
APEC	Association Pour l'Emploi des Cadres (Association for the Employment of Executives)
ARS	Agence Régionale de Santé (Regional Health Agency)
ASH	Social assistance for accommodation
CDD	Contrat à Durée Déterminée (Fixed Term Contract)
CESE	Conseil Économique Social et Environnemental (Economic, Social and Environmental Council)
CNAM	Conservatoire national des arts et métiers (National Conservatory of Arts and Crafts)
CNSA	Caisse Nationale De Solidarité Pour L'autonomie (National Old Age Insurance Fund)
CUI-CAE	Le Contrat Unique D'insertion - Contrat D'accompagnement Dans L'emploi (The Single Integration Contract - Employment Support Contract)
DARES	La Direction De L'animation De La Recherche, Des Études Et Des statistiques (Directorate of Research, Studies, Evaluation and Statistics)
EHPAD	Établissements d'hébergement pour Personnes Âgées Dépendantes (Establishment for the Accommodation of Dependent Persons)
EP	European Parliament
EU	European Union
EUROPOP	Eurostat Population Projections
EUROSTAT	Statistical Office of the European Union
HCFEA	Haut Conseil de la Famille, de l'Enfance et de l'Âge (High Council for the Family, Childhood and Age)
INPES	Institut National de Prévention et d'Éducation pour la Santé (National Institute for Prevention and Health Education)

INSEE	L'Institut National De La Statistique Et Des Études Économiques (National Institute Of Statistics And Economic Studies)
LE	Life Expectancy
LTC	Long-Term Care
NRRP	National Recovery and Resilience Plan
OFCE	L'Observatoire français des conjonctures économiques (French Economic Observatory)
PEC	Parcours Emploi Compétences (Skills Job Path)
PP	Percentage points
PNNS	Programme national nutrition santé (National Health Nutrition Programme)
PSD	Prestation Spécifique Dépendance (Specific dependency benefit)
RCC	Rupture conventionnelle collective (collective bargaining agreements)
SSIAD	Service de soins infirmiers à domicile (home nursing services)
UN	United Nations
USLD	Unité de soins de longue durée (Long-term care units)

EXECUTIVE SUMMARY

Due to the increased ageing population in France since late 60s, the active ageing policies have been present in national policies since that time. The foundations of the policies were based on three elements: the lives of the elderly should be 'active, autonomous and participatory'. Several reforms have been undertaken in different areas, in order to facilitate the lives of the elderly, and make the impact of the ageing more friendly to the society and the economy. The most recent plans reinforcing French economic and social resilience are very extensively present in the NRRP. National reforms include the modernisation of the healthcare system, the support of LTC, as well as the reinforcement of the home-based care for the elderly people.

- **Economic participation:** Efforts were made to increase the retirement age and the stimulation of the economic activity of the elderly. The campaigns combatting age discrimination, as well as the introduction of the more flexible forms of employment of the elderly has been also addressed. COVID-19 negatively affects economic participation of the elderly.
- **Social participation:** Isolation and loneliness affect about a quarter of those aged 75 plus. With a view to prevention and health promotion and a global and positive approach to advancing age, the public authorities have drawn up a national plan for "Ageing Well" and introduced a law "Adapting Society to Ageing". The aim is to prevent chronic diseases, maintain cognitive and physical functioning and encourage the involvement of seniors in social life. Several programmes and initiatives have been implemented since then, with the aim to keep people active physically, mentally, or socially. The COVID-19 pandemic has had a detrimental effect on the mental health of the elderly. They found themselves isolated from their families and loved ones. Therefore, the future policies should address rebuilding the social participation of the elderly in their pre-COVID activities and help them strengthening their mental health.
- **Health and well-being:** In France nearly 3 out of 4 seniors have difficulty in accessing healthcare. For financial or accessibility reasons, some prefer to reduce the frequency of the medical visits, or even abandon the treatment. The elderly often indicate that the access to care is for them too expensive, too distant, and too complicated. The declining medical service in rural areas and the rise of regions, where the medical care is more difficult to access have long been deplored. The development of new technologies applied to the field of health has opened up very important areas, for research and treatment of pathologies as well as for the transmission of information and has raised many hopes. Especially in the rural territories, the telemedicine is perceived as a particularly relevant solution. The NRRP includes significant amount of financing (EUR 2.5 billion) and effort to the modernisation of the healthcare system. It is recommended that part of this funds should improve the provision of the more equal access to the healthcare specialists in the rural regions, when compared to urban and to support the development of the digital technologies, as a mean to combat these inequalities.
- **Long-term care:** Long-term care units in France are defined as structures that support the elderly people, who are no longer independent and whose state of health requires constant and continuous surveillance, as well as medical maintenance treatments. In the majority of cases, long-term care units are divided between both public and private healthcare services. The system is based on the freedom of choice being left to the patient. During the pandemic the beneficiaries of the LTC can be considered as the main victims of the epidemic: the residents of the institutional care were at the higher risk of death due to the residency in shared

buildings, while the recipients of home services were disfavoured in terms of loneliness and isolation.

- **Supportive environments:** The percentage of the elderly staying in the retirement homes increases with age. According to Eurostat France is one of the EU countries which has the highest rate of elderly population aged 85 or over living in an institutional household with a rate of 21 %. The access to the public transport is in general available, but their effectiveness depends on the municipality that operates it.

1. INTRODUCTION

The aim of this country report is to present the insight, analysis and, policy recommendations to the French national ageing policies, defined as the support for the economic and social participation of the elderly, health and well-being, access to long-term care, as well as the creation of the supportive environment. Due to the significant COVID-19 pandemic impact on some elements of the active ageing policies performance, special attention is given to identify the drawbacks, challenges, and opportunities that the crises brought. Good practices are to be identified and policies recommendation at the EU level are provided.

The study is mainly built on governmental documents, strategies, evaluations, reports, French national statistics, and European statistics. In addition to the desk research and to fill the gaps, especially, when it comes to the COVID-19 pandemic impact, two interviews were held with the French stakeholders, representing the institutions being engaged in the implementation of active ageing policies at the national level.

2. ACTIVE AGING IN NATIONAL POLICY

2.1. Demographic background

In France life expectancy (LE) continues to increase since the late 1960s. While the LE stood at 70 years in the 1960s, in 2019 it reached 82.27 years in France. It was higher for women and reached the level of 85.3 years compared to 79.2 years for men¹. The EUROPOP projections show that the LE in 2030 will reach the level of 87.4 years for women and 81.6 years for men². With the increase of LE, the number of people aged 60 and more also increases. France has 20 million people over 60 years old (13 million in 2005), 32 million of 20-59 years old (34 million in 2005), and 15 million of those under 20 years old (15 million in 2005). In 2025, 28.7 % of the French citizens will be 60+.

2.2. Historical context

Active ageing policies addressed to the population aged 60+ in France have been debated and introduced even before the emergence of the concept at the European level. In general, in the past, the care of the elderly was the responsibility of the family. With the emergence of the industrial society, the higher engagement of women in the labour market and the rural exodus, the modes of organisation of the family deeply evolved and gave room for the development of institutional public care and assistance.

Nowadays, although the care of the elderly is very much institutionalised, it should be noted that family continues to play a crucial role in the assistance given to the elderly. The help of family and friends is still much greater than that of the professionals.

The active ageing policies in France have been developed from the middle of the 20th century onwards, first with the structuring of old-age insurance, and later with a specific system of assistance and social action.

2.3. Birth of the old age policy with the Laroque report in 1962

The Laroque report published in 1962 is considered as the founding act of old age policies in France. It was the first to propose a modernistic approach to the definition of old age, i.e., as "*active, autonomous, and participatory*" phase of life. The author clearly stated that "*priority must be given to the integration of the elderly into society, by providing them with the means to continue, for as long as possible, to lead an independent life through the provision of suitable housing, the organisation of the home help, the creation of social services of all kinds that are necessary for them, and the organisation of their occupation and leisure activities*" (following Laroque Report, 1962: 9). Only the Sixth plan of 1971-1975³ introduced the recommendations from the report, which coordinated the activities related to health, social, and home care support (Questiaux Report, 1971). It was also at this time that the social and healthcare sector was structured with the Founding Law of 30 June 1975.

¹ Life expectancy at birth in metropolitan France from 2004 to 2020, by gender.
Available at: <https://www.statista.com/statistics/460418/france-life-expectancy-by-gender/>.

² The 2021 Ageing Report: Underlying Assumptions and Projection Methodologies.
Available at: https://ec.europa.eu/info/sites/default/files/economy-finance/ip142_en.pdf.

³ Le sixième Plan de Développement économique et social (1971-1975).
Available at: <https://www.strategie.gouv.fr/sites/strategie.gouv.fr/files/atoms/files/sixieme-plan-1971-1975.pdf>.

2.4. The "dependency" curve of the 1980 and 1990

With the economic slowdown of the country in the late 80s of the twentieth century, the control of social protection expenses has become a significant topic in the public debate. In order to coordinate the activities and expenses addressed to the elderly, for the first time the position of the Secretary of State for the Elderly was created in 1981, but with a rather limited role. In 1982 the Defferre law was established, which was structuring the responsibilities related to social action and social assistance for the elderly. Since then, several steps related to the transformation and liberalisation of diverse activities related to the active ageing were proposed: - encouragement of the employment of care workers by households (some tax exemptions in 1986, the introduction of care service vouchers in 1993, opening of the LTC sector to for-profit companies in 1996).

2.5. CNSA The 2000s marked by major social policy changes

The significant changes and the proper introduction of the active ageing policies in France took place at the beginning of the 21st century. The Law of 20 July 2001⁴ establishes a new specific social benefit for dependent elderly people. The Personalised Autonomy Allowance or APA replaces the PSD.

The heatwave of summer 2003 revealed the significant drawbacks of the social care system, especially for the elderly. Their isolation and exclusion have emerged as an issue, which had to be dealt with. In response to this, the public authorities reacted with the Law of 30 June, 2004⁵, on solidarity for the autonomy of the elderly and the disabled, which initiated 3 reforms:

- the creation of the CNSA (National Old-Age Insurance Fund is an organisation that manages the retirement of "classic" employees);
- the establishment of an alert and emergency plan; and
- the institution of a day of solidarity intended to finance the reinforcement of interventions in favour of the autonomy of the elderly and the disabled.

The law of 11 February, 2005⁶, for the equality of rights and opportunities, participation and citizenship of disabled people constitute the right of elderly people in situations of autonomy loss.

As in other EU countries, 2012 was devoted to the broad celebration of the European Year of Active Aging, with the aim to *"improve the employment opportunities and working conditions of the growing number of older people in Europe, in order to help them play an active role in society and encourage healthy ageing"*.

Three years later the Law of 28 December 2015⁷, was introduced with the aim to adapt the society to rapidly developing population ageing and to build a society where everyone can age in dignity. It recommends improving and facilitating the daily life of the elderly and their families, especially the most fragile, but also anticipating the ageing of the population for future generations (for example recognise the status of relative caregiver and the creation of a "right to rest", Act II of the personalised autonomy allowance (APA) at home, the deletion of all remaining expenses for beneficiaries of the

⁴ Loi n° 2001-647 du 20 juillet 2001 relative à la prise en charge de la perte d'autonomie des personnes âgées et à l'allocation personnalisée d'autonomie (1). Available at: <https://www.legifrance.gouv.fr/loda/id/JORFTEXT000000406361/>.

⁵ Loi n° 2004-626 du 30 juin 2004 relative à la solidarité pour l'autonomie des personnes âgées et des personnes handicapées (1). Available at: <https://www.legifrance.gouv.fr/loda/id/JORFTEXT000000622485/>.

⁶ La loi du 11 février 2005 pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées Available at: <https://handicap.gouv.fr/vivre-avec-un-handicap/handicap-accessibilite-et-deplacement/article/loi-du-11-fevrier-2005>.

⁷ Loi du 28 décembre 2015 relative à l'adaptation de la société au vieillissement. Available at: <https://www.vie-publique.fr/loi/20717-adaptation-de-la-societe-au-vieillessement-dependance>.

Personalised solidarity allowance for the elderly (ASPA), ensure quality support, both at home and in an institution etc.).

Since 2018 the French government has introduced the Aging and Autonomy Act⁸. The aim of this Act is to focus in particular on the support and development of policies for maintaining elderly people at home and on the reorganisation of the functioning of the medical retirement homes for the elderly, who lost their autonomy - EHPAD (Establishment for the Accommodation of Dependent Persons)⁹. In more detail, the Act aimed at:

- Improve the carer recruitment, salaries, training and diplomas in EHPADs as well as in the home help sector.
- Create of a new model of EHPAD opens towards the outside world (home, hospital, etc.) in order to decompartmentalize the establishments.
- Implement the fifth branch of Social Security dedicated to the financing of long-term care and harmonise nationally the access and quality of the offer.

As of 2021, Social Security insurance has five branches: autonomy will be added to sickness, family, work-related accidents and retirement. The management of this fifth branch will be entrusted to the CNSA. The aim will be to have a global vision of the resources devoted to autonomy and to allow better management of public policies.

However, the COVID-19 crisis has had an impact on the government's schedule, resulting in yet another postponement of the project of the legislation on Aging and Autonomy Act. With the "new normal" being observed, the works on the Act has again started. Nevertheless, the upcoming elections might again delay the reform due to the sensitivity of the topic in French society. In fact, for years, successive governments in France have passed laws or established reforms on the ageing of the active population without taking into account certain parameters such as the arduousness of certain jobs, the social benefits of certain branches of activity, etc., and they have generated anger, mistrust, demonstrations and even repeated strikes within French society. This is what we have seen during the last *Yellow Vest Protesters*, which lasted for months before the crisis of the COVID-19.

⁸ Report of the consultation on old age and autonomy. Available at: <https://solidarites-sante.gouv.fr/affaires-sociales/autonomie/consultation-place-des-personnes-agees/concertation-grand-age-et-autonomie/>.

⁹ EHPAD are responsible for the institutional and medical support of the fragile and vulnerable elderly, to support their autonomy through comprehensive care, including, accommodation, feeding, providing care and leisure. Their activities are addressed to people aged 60 plus, who are in a need of a daily support due to the physical or mental problems (like Alzheimer's disease). Available at: <https://www.pour-les-personnes-agees.gouv.fr/vivre-dans-un-ehpad/les-differents-etablissements-medicalises/les-ehpad>.

3. ASSESSMENT OF ACCESS TO SERVICES FOR OLDER PEOPLE

3.1. Economic participation

3.1.1. Older people on the labour market

The employment rate of 55-64 years old has risen significantly in France, from 37 % in 2003 to over 56 % in 2018 according to the Directorate of Research, Studies, Evaluation and Statistics (Dares)¹⁰. Nevertheless, it is still lower than among other age groups. On top of that, significant disparities among older people are observed. The employment rate of "young seniors" aged 55-59 has risen considerably over the past 20 years. It reached the level of 72 % in 2017, a higher average than in all European countries. However, the proportion of older people working falls sharply after the age of 60. In 2017, the employment rate of 60-64 years old was only 31 % (6.5 % for 65-69 years old). Despite the increase of the retirement age (62 in 2021), it appears that the early withdrawal from economic activity in France remains high.

Older people are at higher risk of remaining unemployed for a longer period of time. 60.2 % of unemployed aged 55-64 have been unemployed for at least one year, compared to 41.8 % of 15-64 years old. The unemployment rate and the share of long-term unemployed do not differ much between older people aged 55 to 59 and those aged 60 to 64.

After age 55, part-time work increases with age. It is around 30 % for those aged 60 - 63 and reaches the level of 41 % for people aged 64. The increase with age is observed for both sexes, regardless of the fact that women work part-time much more than men, both among seniors (35 % versus 10 %) and at intermediate ages (29 % versus 6 %)¹¹. Older workers are more likely than younger workers to report working part-time for personal and domestic reasons (21 %) and for health reasons (14 %)¹².

3.1.2. Pension reforms in France

Four pension reforms have succeeded one another in France since the early 1990s, i.e., 1993, 2003, 2010, and 2014. The pension reform of 2010 raised the legal retirement age from 60 years to 62 years. The legal age at which an employee can retire is currently 62 years. The full retirement age, to which an employee is entitled regardless of the number of years of contributions, was previously set at 65 years. This age will be gradually raised to 67 years by 2023.

The reforms have significantly increased the employment rate of older workers (+8.2 pp between 2007 and 2017, according to INSEE). However, at the same time, the unemployment rate for workers in this age group has risen rapidly, as has the proportion of part-time jobs and fixed-term contracts.

The employment of older workers is the subject of significant debate on the part of the State, the Regions and the social partners, through various measures aimed at encouraging employers to maintain and keep the elderly in the workplace, to hire older workers, to prevent arduous work, to improve older workers' access to training, or to encourage them to continue working after the legal retirement age. These measures have been reinforced as part of the Senior Employment Plan presented in June 2014.

¹⁰ Emploi des seniors: quels enjeux, quelles solutions? Défi métiers, 05 Août 2021. Available at: <https://www.defi-metiers.fr/dossiers/emploi-des-seniors-quels-enjeux-quelles-solutions#:~:text=Le%20taux%20d'emploi%20des%20seniors%20progresse,54%20ans%20d%C3%A9passe%2080%25>.

¹¹ Ibidem.

¹² Ibidem.

3.1.3. Measures and plans to promote the employment of senior citizens

Several specific measures and plans have been put in place for senior citizens in order to counter the difficulties that this group faces in the labour market. The measures were mainly aimed at introducing flexibility to the permanent employment contract being used as a traditional means between employer and employee.

- **Senior CDD (fixed-term contract):** this contract was created to encourage job seekers close to retirement age to return to work, to enable them to supplement their rights in order to benefit from a full pension. It is a "classic" fixed-term contract, but its maximum duration (including renewals) can be extended to 36 months (compared to the usual 18 months). The senior CDD can be concluded by a person aged 57 and over, who has been registered as a job seeker/unemployed for more than 3 months, or who has been granted a Professional Security Contract (CSP13) following a dismissal for economic reasons. The professional security contract (CSP) is dedicated to employees who have been dismissed for economic reasons. The scheme aim is to promote the employee's conversion.
- **PEC14:** a subsidised contract intended for people with difficulties accessing employment, the PEC (which has replaced the CUI-CAE 15, The single integration contract - employment support contract; this is a contract in the non-market sector) since January 2018, when concluded for a fixed term, be extended up to a total duration of 5 years (instead of 2 years) for people aged 50. By way of exception, it may be extended for employees aged 58 or over, until the date on which they are eligible for retirement.
- **Professionalisation contract:** a contract signed between an employer and an employee allowing the latter to acquire a professional qualification (diploma, title, certificate of professional qualification) recognised by the State and/or the sector. Employers who hire jobseekers aged 45 and over under a professionalisation contract can receive state aid (which cannot exceed EUR 2,000 for a single contract).
- **"Emploi franc"**¹⁶: this mechanism allows employers, who hire a job seeker less than 26 years of age who lives in one of the districts eligible for "emplois francs" to receive financial assistance of EUR 2,500 to 5,000 per year for two or three years, depending on the nature of the contract (permanent or fixed-term contract for a minimum of six months). This scheme could be extended to benefit citizens of older age, seniors as well. The company can combine the "Emploi franc" aid with all hiring aids under a professionalisation contract.

3.1.4. The impact of COVID-19 on labour market activity of people 50+, 65+

In the private sector in 2020, 360,500 jobs were destroyed last year according to February figures published by INSEE¹⁷. Only in the last 3 months of 2020 39,600 employees has lost their jobs. For a time being, unemployment figures are rather stable for seniors. Bruno Ducouvré, an economist at the French

¹³ Contrat de sécurisation professionnelle (CSP), Service-Public.fr. Available at: <https://www.service-public.fr/particuliers/vosdroits/F13819>.

¹⁴ Parcours emploi compétences, Ministère du Travail, de l'Emploi et de l'Insertion. Available at: <https://travail-emploi.gouv.fr/emploi-et-insertion/parcours-emploi-competences/pec>.

¹⁵ Le contrat unique d'insertion - contrat d'accompagnement dans l'emploi (CUI-CAE), Ministère du Travail, de l'Emploi et de l'Insertion. Available at: <https://travail-emploi.gouv.fr/emploi-et-insertion/parcours-emploi-competences/cui-cae>.

¹⁶ Qu'est-ce qu'un emploi franc?, Service-Public.fr. Available at: <https://www.service-public.fr/professionnels-entreprises/vosdroits/F34547>.

¹⁷ Les seniors, prochaines victimes de la crise sur le marché du travail?, Mieux Vivre Votre Argent, 24/02/2021. Available at: <https://www.mieuxvivre-votreargent.fr/retraite/2021/02/24/emploi-les-seniors-prochaines-victimes-de-la-crise/#:~:text=Dans%20le%20secteur%20priv%C3%A9%2C%20360.500,f%C3%A9vrier%20publi%C3%A9s%20par%20l'Insee,&text=En%20effet%2C%20leur%20taux%20d'augmenter%20ces%20derni%C3%A8res%20ann%C3%A9es>.

Economic Observatory (OFCE), points out that "protected older workers are more likely to have permanent contracts than younger workers and have benefited more from partial employment"¹⁸. The EUROSTAT statistics show that the employment rate among the elderly remains unchanged between 2019 and 2020. It is the lowest among the elderly aged 65-75 and ranges at the level of 5.3 %-5.5 %, it is stable for those aged 60-64 and ranges at the level of 33 %, and it is the highest among the youngest old, i.e. those aged 55-60 and stays at the level of 73 %¹⁹. But according to this expert, "older workers are likely to pay part of the cost of the crisis". Indeed, their employment rate could decrease due to restructuring and Voluntary Redundancy Plans. Gilles Gateau, Managing Director of the Association for the Employment of Executives (Apec) shares this opinion and says to be "very attentive" to the subject because, on the company side, the temptation to propose early-retirement measures can be very strong.

Apec published a barometer at the beginning of February on the recruitment and mobility intentions of executives and notes "the fear of dismissal which is increasing in particular among the youngest and the oldest". Thus, 84 % of senior executives believe that it would be difficult to find a job equivalent to the one they currently hold²⁰.

Large companies are said to be encouraging senior employees to take early retirement. To do this, they use collective bargaining agreements (RCC) which allow them to eliminate job positions without dismissal. Indeed, seniors are often the best paid, so companies look at the most expensive positions when restructuring²¹.

For the company, the use of contractual termination is less costly than the job protection plans. The conditions are negotiated between employers and employees, so it can facilitate the implementation of departure plans.

This trend was confirmed by sociologist Anne-Marie Guillemard in an interview with Le Monde. "We have remained in the culture of an early exit." (...) For her, the phenomenon of "neither seniors", "neither retired nor employed", could rise with this policy of early retirement, creating "a new area of poverty": "42 % of those who retire are already out of the labour market"²².

She emphasises, however, the need to encourage intergenerational cooperation to improve competitiveness and innovation, through "*the combination of experience and new work*".

The pandemic has the potential to significantly reduce seniors' incomes and quality of life. Already, less than 20 % of those of retirement age are receiving a pension.

The impact of the pandemic will be even greater for women over the retirement age (60-65 or older) as they are the ones to not regularly receive any pension because they either had a short career, chose to raise their children, or received lower wages than men²³.

¹⁸ Ibidem.

¹⁹ Data available at Eurostat: LFSQ_ERGAN, Eurostat, 2021.

²⁰ Les seniors, prochaines victimes de la crise sur le marché du travail?, Mieux Vivre Votre Argent, 24/02/2021. Available at: <https://www.mieuxvivre-votreargent.fr/retraite/2021/02/24/emploi-les-seniors-prochaines-victimes-de-la-crise/#:~:text=Dans%20le%20secteur%20priv%C3%A9%2C%20360.500,f%C3%A9vrier%20publi%C3%A9s%20par%20l'Insee,&text=En%20effet%2C%20leur%20taux%20d,l'augmenter%20ces%20derni%C3%A8res%20ann%C3%A9es.>

²¹ Ibidem.

²² Ibidem.

²³ Note de synthèse: L'impact de la COVID-19 sur les personnes âgées. Available at: https://www.un.org/sites/un2.un.org/files/old_persons_french_0.pdf/.

3.2. Social participation

3.2.1. Social participation among the elderly

According to the French national public health agency (Santé publique), in 2018 13 million people aged 65 and over were living in France, and they constituted 19.6 % of total French population. Isolation and loneliness affected about a quarter of those aged 75 and over²⁴.

The social participation of seniors (autonomous and living at home) can be understood in the sense of "remaining an actor in one's community", "being active and involved in civic activities, as well as in leisure and entertainment activities", without forgetting the relationships between people and particularly between generations²⁵. This social life is characterised by the fact that it can no longer be based on the workplace and must be implemented in a different way – volunteer work, responsibilities in decision-making bodies in cities, local communities, etc.

Promoting this participation, therefore, requires building favourable socio-economic environments and systems; removing obstacles and compensating for the loss of abilities or autonomy.

3.2.2. Policies aimed at reducing social isolation and promoting social participation

In order to prevent loneliness, promote health and increase the positive approach to ageing, the public authorities have created a National Plan for "Ageing well" (2007-2009) (*Plan National Bien vieillir 2007-2009*²⁶) with the aim to enable as many elderly as possible to "age well". The activities involved in the Plan were aimed at the implementation of suitable prevention schemes in personal health and social relations. They were also aimed to strengthen the skills of older people to increase their autonomy and support their health and quality of life at home for as long as possible²⁷. Ageing well in one's mind, body and with others are the themes addressed to advance in age serenely, without forgetting ageing well at home.

For young retirees, practical recommendations and advice were to encourage them to eat well and move to keep their brains active, share activities with friends, and stay connected, without forgetting how to adopt protective behaviours for their body and health.

For people aged 75 and over, the recommendations were concentrated more on the adaptation of the body activities to the age. Special attention was paid to the cognitive functions, nutrition, physical activity, health prevention, meditation and optimism that can help to enjoy one's life.

In 2016 the law "Adapting Society to Ageing (*Loi relative à l'adaptation de la société au vieillissement – ASV Law*²⁸) has been passed. The law was based on three pillars: - to anticipate the loss of autonomy, - to adapt the society to ageing, and - to support people who lost their autonomy.

²⁴ Promouvoir la participation sociale des personnes âgées: le dossier de la revue La Santé en action n° 443, mars 2018. Available at: <https://www.santepubliquefrance.fr/les-actualites/2018/promouvoir-la-participation-sociale-des-personnes-agees-le-dossier-de-la-revue-la-sante-en-action-n-443-mars-2018>.

²⁵ Les solitudes en France, Fondation de France. Available at: https://www.fondationdefrance.org/sites/default/files/atoms/files/les_solitudes_en_france_2016_-_synthese.pdf.

²⁶ Évaluation du Plan national Bien vieillir 2007-2009, Haut Conseil de la santé publique. Available at: <https://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=195>.

²⁷ Thematic dossier Aging well. Available at: <https://www.santepubliquefrance.fr/la-sante-a-tout-age/la-sante-a-tout-age/bien-vieillir#:~:text=bien%20vieillir%20%3A%20une%20approche%20globale,domicile%20le%20plus%20longtemps%20possible>.

²⁸ L'adaptation de la société au vieillissement, Agence régionale de santé, 29 juillet 2019. Available at: <https://www.ars.sante.fr/ladaptation-de-la-societe-au-vieillessement>.

Also, a new entity responsible for the implementation of the programme has been established – the High Council for the Family, Childhood and Age (HCFEA - *Haut Conseil de la Famille, de l'Enfance et de l'Âge*)²⁹ to enhance the public debate and increase the expertise on the topics related to ageing, adaptation of society to ageing, and support of the loss of autonomy among others. The Council is responsible for sending opinions to any draft legislative measures concerning the elderly and retired people, as well as adaptation of society to ageing.

The Pension Funds and Santé Publique France have set up a website pourbienvieillir.fr dedicated to the elderly as well as to health professionals in which they will find advice and tips on several themes (such as well in my head, well in my body, well with others, well at home, well with my balance and well with my pension fund).

The financing of the National Plan for "Adapting Society to Ageing" has been implemented by various governmental organisations at the national and regional level through diverse programmes³⁰. For example, the program around *Promoting A Balanced Diet To Stay Fit After 55* is allocated to INPES (National Institute for Prevention and Health Education)³¹, while the programme *Promoting Physical And Sports Activity*³² is financed by the Ministry of Youth, Sports and Associations.

The Plan states, that while health problems are often the primary cause of loss of autonomy, environmental factors can be also aggravating or, on the contrary, can ease or even reduce their impact on daily life. Therefore, the development of the living environment, from individual housing to collective spaces in neighbourhoods, cities or villages, is considered as an important element that can bring significant benefits for the elderly.

Therefore the programme highlights it is necessary to encourage intergenerational social connections by recreating common living spaces and by using technologies that allow people to be connected, whether in terms of transportation or communication (mail, telephone, radio, TV, Internet, etc.).

It is also necessary to increase the demand for mobility among the elderly by making urban travel safer and by making services, transport and public spaces accessible.

Thus, the development of the initiative at the local level has a decisive advantage in terms of health promotion and the implementation of preventive measures as well as in terms of socialisation and well-being.

3.2.3. The impact of COVID-19 pandemic on social participation

According to the Report prepared by the Ministry of Solidarity and Health³³, the COVID-19 pandemic has exacerbated the social isolation among the elderly and the negative consequences it causes. Poor social relations of the elderly has been already emphasised in the past in the public report prepared by CESE on "Combating isolation for more cohesion and fraternity"³⁴. Therefore, as a rapid response to increased social exclusion and isolation, the Health Minister introduced the "Plan Blue" in March 2020 to limit the negative consequence of COVID lockdown towards the elderly people³⁵. Within this framework several measures were proposed to fight social isolation, where the most actionable one

²⁹ Le HCFEA. Available at: <https://www.hcfea.fr/spip.php?article10>.

³⁰ The ARS website. Available at: <https://www.ars.sante.fr/>.

³¹ The PNNS website. Available at: <https://www.mangerbouger.fr/PNNS>.

³² Ibidem.

³³ Lutter contre l'isolement des personnes âgées et fragiles isolées en période de confinement. Available at: https://solidarites-sante.gouv.fr/IMG/pdf/rapport_no1_i_quedi_-_05042020.pdf.

³⁴ Combattre l'isolement pour plus de cohésion et de fraternité.

³⁵ Lutter contre l'isolement des personnes âgées et fragiles isolées en période de confinement. Available at: https://solidarites-sante.gouv.fr/IMG/pdf/rapport_no1_i_quedi_-_05042020.pdf.

included:

- Creation of a free national phone line that the elderly could use when they feel lonely, need psychological support, advice, or guideline.
- Dissemination and promotion of the usage of digital solutions to maintain social relationships with family and friends.
- Active engagement of local authorities in the provision of support and guideline for the elderly.
- Mobilisation of new local resources such as building caretakers, postmen, civil servants in diverse territorial actions to support the elderly (helping them to do shopping, cooking for them, providing them with support in daily activities).

Although there is no comparable data on the impact of the COVID-19 pandemic on the social isolation of the elderly, the existing studies show that around 46 % of the elderly aged 65 plus and 52 % of those aged 50-64 felt at least isolated from friends and family. 32 % of the elderly aged 65 plus felt isolated, while the corresponding number for those aged 50-64 was 34 %. Nevertheless, the share of people feeling isolated was the lowest among the oldest group of people - 65 plus (when compared to the youngest generations, where the share corresponds to 42 % of people aged 18-34³⁶).

3.3. Health and well-being

3.3.1. Access to healthcare

The French healthcare system, although generally recognised as one of the best services of public healthcare in the world, nowadays is significantly affected by the ageing population and by regional inequalities³⁷. It is constructed as a fully integrated network of public and private hospitals, primary care, out-patient care and other medical service providers. The system is addressed to every citizen, irrespective of wealth, age or social status. It is funded by obligatory health care contributions from the salaries, as well as by funds from the central governmental budgets. Also, the healthcare beneficiaries are obliged to contribute with the so-called user fee - a symbolic amount of money, which they have to pay for the delivery of the healthcare services.

At present nearly 3 out of 4 seniors have difficulty in accessing healthcare³⁸. For the elderly, access to health care can be difficult. For financial or accessibility reasons, some prefer to reduce the frequency of their treatment, or even to stop it completely, to the detriment of their health. The elderly often indicates that access to care is too expensive, too far, and too complicated. The financial cost is an argument that complicates access to healthcare for some seniors. They indicate that the user fees, they are obliged to pay for all types of care, are very often too high for them, and not reimbursed by the healthcare insurance system.

On the other hand, access to healthcare is not equally distributed among the country³⁹. Despite the "Bachelot" reform being implemented in 2010, with the aim of improving the territorial inequalities in terms of access to healthcare, the gap in access to healthcare continues to widen between French territories. The regions, where access to healthcare (in terms of primary care, access to specialists,

³⁶ M.Foucault, Crise sanitaire et isolement social, SciencesPo, Policy Brief, Septembre 2020. Available at: https://www.sciencespo.fr/cevipof/attitudesoncovid19/wp-content/uploads/2020/09/Note11_FOUCAULT_social-isolation.pdf.

³⁷ The French health care system. About France. Available at: <https://about-france.com/health-care.htm>.

³⁸ DOMITYS met la santé au service des seniors avec le 1er cabinet médical connecté en Loir-et-Cher, DOMITYS. Available at: <https://www.domitys.fr/sites/default/files/Domitys/pdf/DOMITYS%20-%20CP%20T%C3%A9l%C3%A9medecine%20x%20Blois.pdf>.

³⁹ Composition du groupe de travail. Available at: <http://www.senat.fr/rap/r19-282/r19-2821.pdf>.

pharmacists, or nurses) is limited, are called "medical deserts" (*Deserts médicaux*). In these regions, some patients do not have a medical practice close to their home and do not have the possibility to travel several kilometres to access care. Nowadays, the regions with limited access to healthcare constitute around 30 % of all municipalities in France. Around 9-12 % of all French population live in such regions (an estimate of around 5.4 million people)⁴⁰.

Faced with these difficulties, some seniors decide to space out their visits to their doctor, even if they are necessary. Others give up consulting a specialist when they do not consider it essential and suspend their treatment, even though it is prescribed by a professional. Still, others have resorted to self-medication for the treatment of small pains considered benign⁴¹.

The regional differences in access to healthcare, but also in the need for healthcare, are seen when rural and urban areas are compared. It appears that rural inhabitants are regularly followed up by their general practitioner, but *"a generalised lack of prevention and early care is most often noted: certain diseases are detected or treated later than elsewhere, a situation experienced acutely in very rural and isolated areas due to phenomena linked to the current evolution of medical demography. Some people do not seek treatment because of a lack of financial means or because there is no care nearby"*⁴².

The declining medical service in rural areas and the rise of medical deserts have long been deplored.

The problems encountered in rural areas are the following:

- The density of private nurses is slightly higher than average in rural France, and their number has increased significantly since 1980 (almost 100 %), in parallel with the ageing of the population, but there is an inequality in their location on the territory. These private nurses prefer to establish themselves in areas of overcrowding to the detriment of undercrowded areas.
- The distances and journeys to consult a specialist or a practitioner are getting longer and longer (3 minutes in town and 4.6 minutes in isolated rural areas for a general practitioner). Rural areas, with low population density, are far from local care and most specialised care.
- Unequal distribution and evolution of health professionals and health care facilities in the country. For the whole country, the median theoretical access time to a health care facility is now 21 minutes, but it varies from 9 to 42 minutes depending on the health territory. Disparities are observed within each region, and even more so between departments. The most rural departments have the highest access time to a hospital. Added to this is the fact that for these territories the "specialised" hospital disciplines: thoracic and vascular surgery, neurosurgery, cardiac surgery, care for severe burns, etc., require extensive travel.

The development of new technologies applied to the field of health has opened up very important areas, for research and treatment of pathologies as well as for the transmission of information and has raised many hopes. Especially in the rural world, where telemedicine is perceived as a particularly relevant solution.

Regarding local access to general practitioners as well as to nurses to be provided in isolated areas, various applications are of obvious interest: teleconsultation which (in dialogue with a nurse) avoids travel with its risks, for the elderly; teliagnosis which allows a specialist to interpret remotely the

⁴⁰ EC, 2019, State of Health in the EU, France, Country Health Profile 2019. Available at: https://ec.europa.eu/health/sites/default/files/state/docs/2019_chp_fr_english.pdf.

⁴¹ Un Français sur deux en milieu rural a du mal à avoir accès à un médecin, Capgeris, 12 décembre 2018. Available at: <https://www.capgeris.com/sante-1731/un-francais-sur-deux-en-milieu-rural-a-du-mal-a-avoir-acces-a-un-medecin-a41968.htm>.

⁴² Ministère des Solidarités et de la Santé. Available at: www.solidarites-sante.gouv.fr.

results of analyses done on-site, teleradiology with the reading of medical images, remote monitoring at home, and more general communication, exchanges, sharing of files are all services that improve the monitoring and treatment of patients, especially isolated elderly.

3.3.2. Impact of COVID-19 on healthcare access

Covid-19 highlighted the inadequacy and underfunding of care and support services for older adults. Many older people do not have access to the care and support services they may need to lead independent, self-sufficient lives of their choosing, or they have no say or control over them.

Therefore, one of the pillars of the French National Recovery and Resilience Plan focuses on the health and economic, social and institutional resilience, which includes reforms and investments in modernisation of the health system. The planned investments cover renovations of the hospitals and healthcare facilities, building outpatient facilities and modernisation of medical infrastructure and equipment. Over EUR 2,5 billion are planned for those actions. The investments are part of the National Strategy for reform of the healthcare system.

3.4. Long-term care

Long-term care units (Unité de soins de longue durée or USLD) in France are defined as structures that support elderly people, who are no longer independent and whose state of health requires constant and continuous surveillance, as well as nursing. In the majority of cases, long-term care units function as public or private health units. The system is based on the freedom of choice of the patient and the resident: each patient is free to choose his or her own doctor, a specialist with direct access, his or her own health care facility, and his or her own accommodation structure, in both the public and private sectors.

Elderly people can either be taken care of by their families, remain at home in complete autonomy or be cared for in the following LTC facilities:

- residential or temporary care for the elderly: are provided by numerous institutions offering different levels of service. These include homes that offer a range of non-medical facilities (such as food and laundry) but almost no medical care;
- nursing homes (or EHPAD) that house the elderly but also offer medical care;
- long-term care units for people whose health requires constant medical monitoring for the very sick and dependent;
- intermediate services that house frail elderly people for short periods, who do not live in residential services. The financing of residential institutions for the frail elderly is currently shared between the health insurance system, which covers the cost of medical care, the regional councils, which cover the cost of personal expenses related to loss of autonomy, and the users, who mainly cover the cost of housing and food; and
- home care: intermediate care services provide temporary care for dependent patients and respite for their caregivers. They promote greater integration and independence for dependent persons. Home care is mainly provided by independent doctors and nurses and, to a lesser extent, by home nursing services (SSIAD), which provide nursing care (grooming) or nursing acts (dressings, distribution of medication, injections), care financed by the health insurance or by the home assistance and support services (SAAD), which provide, within the framework of social assistance, household services and personal assistance services for

ordinary activities and the essential acts of daily life (maintenance of the home, laundry, preparation of meals, shopping, assistance with grooming, help with dressing and undressing).

In order to meet the medical and daily needs of the very dependent elderly residents, long-term care units offer increased medical care. These services include:

- permanent medical surveillance;
- nursing care, hygiene and comfort;
- the presence of a night watchman;
- a diet adapted to health problems;
- motor rehabilitation, if necessary; and
- assistance in the gestures of daily life.

Long-term care units also provide all services related to the accommodation and well-being of residents, as in EHPAD (i.e., residential care for dependent elderly people): full board catering, laundry, and entertainment.

The USLD (LTC Units - Unites de soins de longue durée) team also has the role of accompanying the elderly person in their return home or to an institution.

LTC units belong to the healthcare sector, but they operate on the same model as EHPAD. A three-party agreement must be signed between the facility, the General Council and the Regional Health Agency (ARS). These agreements, which have been mandatory since 2002 for all establishments housing dependent elderly people, govern the pricing of LTC units and EHPAD.

The fee for accommodation in the LTC units is therefore broken down into three expenditure items:

- accommodation rate: this covers the so-called hotel services (accommodation, catering, etc) paid by the resident;
- dependency rate: this depends on the resident's GIR and covers services related to the loss of autonomy - paid by the resident; and
- care rate: it covers hospital and medical expenses - paid by the health insurance.

The financial aid available to residents of long-term care units is as follows:

- Social assistance for accommodation (ASH): this covers part of the accommodation costs of a resident with limited resources (in long-term care units entitled to social assistance).
- Personalised autonomy allowance (APA): it contributes to the financing of the dependency rate for residents of GIR 1 to 4 (determined by the AGGIR scale for evaluating loss of autonomy).
- Housing subsidies: these cover part of the accommodation cost (in long-term care units that have been approved or whose rooms meet specific criteria).

3.4.1. The reforms of long-term care system in France

Taking all sectors together, long-term care (LTC) capacity has continued to decline since 2002. The Table below presents the number of beds in different facilities, which shows its constant decline. This fall can be explained by the implementation of the reform of the pricing system for accommodation establishments for dependent elderly people (EHPAD). This reform notably provides for the transformation of long-term care units (USLD) and retirement homes in hospitals and local hospitals

into EHPAD⁴³. The follow up of the reform is also found in the proposal of the reform being promoted by the President Macron, which aspires at making the "aging at home" a new norm rather than the long-term stay in the institutional home cares⁴⁴.

Table 1: Number of beds in different facilities

	2009	2018	Annual evolution of number of bed on average 2018/2009 in %
USLD	47,966	31,302	-4.6
EHPA	59,966	27,020	-8.5
EHPAD	496,237	594,684	2.0
SSIAD	108,181	127,117	1.8

Source: Drees, comptes de la santé, à partir de données CNAM; DREES, SAE⁴⁵.

The distribution between private and public facilities is also based on geographical and socio-economic data. The daily rate in the private sector (between EUR 50 and EUR 70 at the lowest and with no upper limit) implies being as close as possible to middle- and high-income populations, hence their massive presence around large cities or on the Côte d'Azur for example. The public sector, with a rate of about EUR 50 per day in rural areas and up to EUR 65 in the Paris region, is aimed at the largest number of people. Thus, local authorities, through publicly managed establishments, choose to offer accommodation to their population, regardless of their income. While the private sector is looking for locations with a high potential return.

3.4.2. The impact of the COVID-19 pandemic

From the point of view of the direct repercussions of the epidemic, the elderly people can be considered as the main victims of the epidemic: nearly 40 000 deaths of the elderly people were reported in the nursing homes in France since March 2020⁴⁶; according to the Public Health Agency, the median age of death was 84 years and 90 % of the people who died as a result of COVID-19 were 65 years old or more⁴⁷.

The desire to protect vulnerable people has come up against issues of respect for the fundamental rights of individuals. Patients and residents were confined without the possibility of leaving.

The relationship with patients has evolved in a particular way. For patients in care homes who did not want to stay in their rooms, the caregivers were obliged to lock them in their rooms to avoid the risk of contamination and the spread of the virus. Psychologically, these measures were difficult for both

⁴³ Ph. Baqué, La réforme qui fâche, Le Monde diplomatique, Mars 2019. Available at:

<https://www.monde-diplomatique.fr/2019/03/BAQUE/59612#:~:text=Cette%20r%C3%A9forme%20organise%20une%20convergence,les%20tarifs%20soins%20et%20d%C3%A9pendance.&text=Une%20enveloppe%20de%20150%20millions,qui%20verront%20leurs%20dotations%20diminuer>.

⁴⁴ La réforme du grand âge et autonomie. Available at:

<https://solidarites-sante.gouv.fr/affaires-sociales/autonomie/consultation-place-des-personnes-agees/concertation-grand-age-et-autonomie/>.

⁴⁵ Les soins de longue durée aux personnes âgées. Available at: <https://drees.solidarites-sante.gouv.fr/sites/default/files/2021-03/31-13.pdf>.

⁴⁶ Après la crise sanitaire, comment réformer les Ehpad?, Europe1, 08 juin 2021. Available at: <https://www.europe1.fr/sante/apres-la-crise-sanitaire-comment-reformer-les-ehpad-4050406>.

⁴⁷ Th. Deszpot, L'âge moyen des victimes du COVID-19 est-il de 81 ans?, LCI, 2 septembre 2020. Available at: <https://www.lci.fr/sante/coronavirus-sante-publique-france-epidemie-l-age-moyen-des-victimes-du-covid-19-est-il-de-81-ans-2163463.html>.

parties. The suspension of collective activities and voluntary interventions, and the suppression of family visits also accentuated the feeling of confinement and clausturation. The confinement had a detrimental psychological impact, with mood disorders, confusion and even post-traumatic syndrome.

The French National Recovery and Resilience Plan (NRRP) includes the fifth branch of Social Security and long-term care and independent living reform. As explained above, since 2021 Social Security insurance in France was extended for the fifth branch, namely the financing of the long-term care and harmonisation of the national access and quality of the offer. The management of this fifth branch will be entrusted to the CNSA and it will be financially supported by the NRRP.

3.5. Supportive environments

3.5.1. Housing

France housing policy for the elderly goes back to 1962 with the Laroque report which was fundamentally oriented in favour of "home support" for the elderly. The creation in 1997 of the Specific Dependency Benefit (PSD), which a few years later became the Personalised Autonomy Allowance (APA), was an important step forward to further support the elderly at home. The Aging law of 28 December 2015, focus on providing quality support, both at home and in a retirement home⁴⁸.

Some research, including the recent Libault's report "Grand Age et Autonomie", reiterated that the vast majority of elderly want to live in their own home. This is driven by multiple factors:

- close to family, friends;
- attachment to the known environment;
- the need to preserve a sense of autonomy and freedom (diet, sleep pattern);
- ability to choose their condition of life and potentially to die; and
- economical as cheaper than being in a specialised home such as a care home⁴⁹.

On the other hand, staying at home and home support has its own associated risks impacting the elderly; social isolation, deterioration in the quality of assistance received due to the productivity requirements of the home carer, insufficient support time and care, rapid turnover of home carer⁵⁰.

When their healthcare status deteriorates, this is when usually they are taken to retirement homes. Often there is a rapid deterioration in the condition of the elderly person following entering an institution i.e., EHPAD as a result of a psychologically difficult break-up⁵¹.

For those who are unable to live at their own home, France has various types of housing base on elderly autonomy and health state. Apart from the residencies offering medical treatment described in section 3.4 Long term care, older people can live in:

- Accommodation facilities for the elderly (EHPA);
- Rural nursing home for the elderly (Marpa).

⁴⁸ Loi relative à l'adaptation de la société au vieillissement, Ministère des Solidarités et de la Santé. Available at: <https://solidarites-sante.gouv.fr/affaires-sociales/personnes-agees/accompagnement-des-personnes-agees/article/loi-relative-a-l-adaptation-de-la-societe-au-vieillessement>.

⁴⁹ Concertation. Grand âge et autonomie, Dominique Libault Mars 2019, p. 24. Available at: https://solidarites-sante.gouv.fr/IMG/pdf/rapport_grand_age_autonomie.pdf.

⁵⁰ *Ibidem*, p. 25.

⁵¹ *Ibidem*, p.25.

The percentage of the elderly staying in retirement homes increases with age. According to Eurostat France is one of the EU countries which has the highest rate of elderly population aged 85 or over living in an institutional household with a rate of 21 %. By comparison, Germany is 19 %, Italy – 5 %, and Poland – 3 %⁵².

At the regional level, the rate is 29 % in Pays-de-Loire, 25 % in Bretagne, 17 % in Ile de France, 11 % in Corse, and 7 % on average in French overseas territories⁵³. Multiple reasons might explain the regional difference:

- regional demographic;
- places available in retirement home;
- presence and availability of family; and
- development of home help services can help seniors stay at home.

The studies⁵⁴ show that they are not happy when staying in retirement homes. They reported suffering a lot with their daily life and not being able to find their marks there and expressed a deep regret for their life at home where they had a certain autonomy which is now feels lost. The quality of the services offered for the elderly in Ehpad is perceived negatively in several ways:

- gap between the cost of care and the quality of service offered; degraded service due to financial issues in both public and private sector;
- inequality in terms of quality of care offered between institutions; and
- support too exclusively focused on care; elderly being treated as sick people.

According to Santé Magazine⁵⁵, COVID-19 has highlighted the crisis being experienced by the Ehpad and there is a need to rethink their financial model.

The EHPAD model is disputed. As mentioned above, the French overwhelmingly favour staying at home, while France has one of the highest rates in Europe of over 85 living in institutions.

To address the challenges described above, a national consultation was done with the intention to become law. Its main lines are already known⁵⁶:

- Make it possible for the elderly to stay at home for as long as possible; entrance to retirement home should be seen as the last resort because the majority of elderly want to stay at home up to their end of life. The government will invest EUR 550 million towards home support.
- A new model of a nursing home to be created towards openness to the outside, more collaboration with hospital and medicalisation. A renovation plan of EUR 3 billion over 10 years for nursing homes and independent residences.

⁵² Archive: People in the EU - statistics on an ageing society, Eurostat. Available at: <https://ec.europa.eu/eurostat/statistics-explained/index.php?oldid=358178>.

⁵³ Hilary, S., Legrand, M-M., Pen, L. (Insee), Près de 110 000 seniors dépendants en plus d'ici 2050, INSEE Institut National de la Statistique et des études économiques. Available at: <https://www.insee.fr/fr/statistiques/4806037>.

⁵⁴ Concertation. Grand âge et autonomie. p. 25.

⁵⁵ Dans les Ehpad, la crise du COVID-19 révèle les effets délétères des politiques d'austérité, Santé Magazine. Available at: <https://www.santemagazine.fr/sante/droits-demarches/dans-les-ehpad-la-crise-du-covid-19-revele-les-effets-deleteries-des-politiques-dausterite-442646>.

⁵⁶ Concertation. Grand âge et autonomie.

3.5.2. Transportation

In France, there is no law that imposes a reduced transport rate on an age basis to public transport organisation⁵⁷.

Since the decentralisation law of 1982, 1983, and 13 August 2004⁵⁸, elderly transport organisations, their type and accessibility fall with the local government (municipalities, departments or regions) responsibilities.

As a general rule, for those elderly who local travel has become difficult some local government offer transport solutions at a reasonable price and subject to meeting the eligibility criteria.

The types of transport include:

- individual transport on request: taxi or collective taxi;
- shuttles to facilitate travel to markets, supermarkets, etc.

They also offer public transport cards at reduced prices and sometimes even free for retired elderly, subject to income.

Nevertheless, there are regional differences in the transport accessibility for the elderly, but also the demand for such services. If we look at the Ile de France region, the elderly have free access to public transport subject to eligibility criteria while in Marseille this is done at a reduced rate.

The SNCF (French State Train Company) offers multiple services at the national level:

- access to Senior Advantage Card for over 60 years old against EUR 49 per year to get 30 % discount on all INOUI TGV routes included in Europe, Intercity and TER (regional train);
- access to "Accès Plus" service which provides free reception at the station and accompaniment to the train.

Also, several private solutions are available in France. The Agirc-Arrco, a supplementary pension fund for employees and executives in the private sector, has more than 12.6 million retirees (source: key figures Agirc Arrco 2018). As part of its social action, the fund offers to its retirees aged 75 and over the "Sortir + Service" to allow them to reconnect with going out by being accompanied by a trusted person.

3.5.3. Financial independence

The elderly who has lived and worked in France are entitled to receive the state pension. For those who are unable, the "minimum vieillesse" was introduced in France in 1941. Its objective remains to guarantee a minimum of income to the elderly without a pension or with low resources. The system has been the subject of multiple reforms until 01 January 2006 where it was replaced by the ASPA (solidarity allowance for the elderly).

Entitlement of ASPA start from age 65, it is a monthly payment that is paid to retirees living in France regardless of their nationality by their pension fund. Its amount depends on elderly income and assets. The amount of ASPA can add up to personal income to a certain limit.

⁵⁷ Quelles réductions s'appliquent aux seniors dans les transports en commun, Service-Public.fr, 05 août 2021. Available at: <https://www.service-public.fr/particuliers/vosdroits/F18537>.

⁵⁸ LOI no 2004-809 du 13 août 2004 relative aux libertés et responsabilités locales (1), Journal officiel électronique authentifié n° 0190 du 17/08/2004. Available at: https://www.legifrance.gouv.fr/download/pdf?id=dp1yL2vpT76UJ5WXKQYvW_W-c5JqEb-SEAz0MfCl1vU=:

4. RECOMMENDATIONS FOR THE EU-LEVEL

The results presented in the previous sections give a general overview of what can be undertaken at the EU level, which could support the stronger implementation of active ageing policies in France.

First of all, the policies addressed to the elderly have been developed in France before the introduction of the active ageing concept on the international level. Therefore, the active ageing policies are recognised in different areas, regarding among others labour market, health care and social policies, and not treated coherently as one concept. Also, the unequivocal definition of the old person is not present in French state legislation. Depending on the law, people aged 60 plus are called differently: retired people, elderly people, senior citizens, dependent people, the elderly, the third age, or even the fourth or even fifth aged cohort. Therefore, the challenges related to the ageing societies in France are tackled in a fragmentary manner. Recent fragmented implementation of the active ageing policies, being found under different laws and reforms, leads to the fragmentation of solutions and its partial inefficiency. The active ageing policy in France should therefore be considered in a more holistic way, addressing comprehensively the whole problem.

The active ageing concept should also take into account that it covers diverse cohorts, with very different needs. While people aged 60-62 are usually still in a good mental and physical state, the active ageing policies addressed to them should be more concentrated on their economic activation and the need to introduce more flexibility in their work – for them, as well as for employers. The next cohorts among the elderly, with the deterioration of health, require more attention with respect to their social engagement, access to high-quality healthcare services, or healthcare prevention. Whereas the oldest elderly, especially in France, need more institutional LTC support. These diversities are not very well depicted in the French law (maybe because of the fragmentation of the active ageing policies, and the lack of a unified concept of active ageing). This makes the system complicated and non-understandable. The centralisation of the management of the active ageing measures and the clarity of the strategy encompassing all aspects of active ageing policies would help the elderly people to understand and to comprehend the support they are eligible for within the French social system.

In terms of the particular elements of the active ageing policies, the following recommendations are included:

- **Economic participation:** In France still, not enough older persons aged 60 plus are included in the labour market. There is still a need for more people to work until a later age. While the pension reforms have increased the retirement age and have increased the employment rate of the elderly, still more people should stay in the labour market. The policies addressed to increase the flexibility of the employment of the elderly, but also their job security should be better spelt out and should be clearer. Lack of trust in the job security by older employees is one of the obstacles being mentioned, as a reason for the lower economic participation of the elderly.
- **Social participation:** Policies and programmes addressed to the increase of the social participation of the elderly, are well-designed and straightforward. The diversity of the programmes have been implemented in the last decades. Activities related to the increase of the elderly's participation in sport activities, social activities, as well as daily activities have been implemented at the regional and local levels. The COVID-19 pandemic had a very detrimental impact on the services, and right now, it is important to sustain the activities, approach the individuals and encourage them to return to their social lives.

- **Healthcare and wellbeing:** The emerging problem in this area concerns two elements: significant inequalities being observed at the regional level in terms of access to the healthcare services and specialists, as well as the quality of the services offered. There is an urgent need to support the depopulating, very often rural regions, where the population is ageing faster, with the supply of specialists and doctors, being available for the elderly. The distance between the patient and the specialist is very often an important obstacle for the elderly, discouraging them to undertake the doctor's visit. Also, the campaigns among the elderly encouraging them to use the healthcare services despite the obstacles and raising their awareness of the prevention measures would be welcome.

What is more, the integration and coordination of activities between the social care services, healthcare services and long-term care services is also an important issue. The fragmentation of the system, already mentioned above, creates a misunderstanding of the support within the active ageing policies.

The investment in digital technology in the healthcare sector, although already implemented, still requires better coordination and monitoring. The pandemic exposed all existing weaknesses of the French healthcare system - a lack of coordination among many actors involved in care, the inability to use the digital solutions efficiently and a lack of qualified staff.

- **Long-term care:** While still being partly divided between the healthcare and social care sector, the LTC offers a range of LTC services, with the freedom to choose the best one for an individual. The variety of services offered, the variety of residential care, makes the sector very robust, but also very much complex and therefore complicated. The system is based on the institutional residential LTC, while the public healthcare services at the patient's home are less accessible. The expectations of the elderly are to live in their own house as long as possible, therefore the *Grand age* reform, being promoted by President Macron, which supports the stronger development of the home-based care is a good direction towards responding to the elderly people's preferences.
- **Supportive environments:** This aspect of the active ageing policy in France requires more attention and support. While there are solutions to address the architectural barriers, or providing dedicated public transport for the elderly, regional differences exist in this respect. A specific EU action in this area would be of particular importance, especially in light of the use of ICT technologies for that purpose. Stronger public-private partnerships for better management of the supportive assistance would be also welcome.

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The study provides an overview of the most recent developments with regards to ageing policies and access to services by older people in France. It focuses on six areas: active ageing, economic participation, social participation, health care, long-term care, and supportive environments. The study includes examples of best practices regarding access to services and assesses the impact of COVID-19 pandemic on the well-being of older people.

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