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1 Executive Summary

After a major pension reform introduced in 2010, changes in the French pension system have been relatively less significant in 2011. The social partners have signed an agreement in March 2011 in order to adapt the parameters of the AGIRC and ARRCO schemes to the 2010 reform of the statutory schemes. They have also further harmonised the rules governing the two schemes, thereby opening the door for a possible future merger of the two schemes. Following threats for the rating of French sovereign debt, the government decided in November 2011 to accelerate the pace of the 2010 reform and to increase the minimum statutory retirement age to 62 years by 2017 instead of 2018.

Since a presidential and a legislative election are due to take place in spring 2012, pension reform has been discussed as part of the electoral campaign. While the current right-wing majority has been preparing public opinion for future increases in the retirement age, left-wing parties have promised they will reintroduce a minimum retirement age of 60 years. Public debate has mostly focused on this issue. The issue of the unification of the pension system and the introduction of an NDC system has remained confined to expert circles.

Due to the economic crisis, statutory and supplementary pension schemes have continued to be in deficit. The government has tabled on the fact that the increase in the retirement age will help to reduce these deficits in the next few years. However, the effectiveness of the 2010 reform will depend on whether older workers will be able to find employment. The low employment rates of older workers remains one of the main problems for the financial and the social sustainability of the French pension system.

In 2010 and 2011, there has not been any important reform of the French Health care system, since the most important reform was adopted in 2009 (*loi HPST*) and since the government was concentrated on the pension reform in 2010. However, since the sickness insurance funds deficit are still high (EUR 11,6 billion in 2010 and around 10 billion in 2011), some financial measures have been decided in late 2010 and in late 2011 within *Loi de Financement de la Sécurité sociale*. Inequalities in health are still also a major problem for the French health care system.

The government had announced in 2007 that long-term care would be one of its priorities under its five year term in power, and that a reform would be undertaken to better cover the needs of the dependent elderly. This reform has been repeatedly postponed, and although a national "debate on dependency" (*débat sur la dépendance*) was staged in 2011 with the aim of proposing new measures by the end of the year, the government has finally announced in January 2012 that no new measure would be taken in the near future.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

As stated by the EU Commission, France was relatively less affected than other Member States by the economic and financial crisis, with a decline of 2.7% in GDP in 2009, partly due to sizeable economic stabilisers and the resilience of household consumption. The banking sector also proved to be resilient. In 2010, the economy recovered and, overall, GDP growth came out at 1.5%, and 1.7% in 2011. However, the economic crisis has substantially impacted France's public finances. Due to the automatic stabilisers and discretionary fiscal stimulus, the general government deficit rose from 3.3% of GDP in 2008 to 7.5% in 2009, 7.1% in 2010, and probably 5.4% in 2011. Similarly, the crisis has exacerbated the insufficient utilisation of labour and the structural weaknesses of the French labour market, where there was a relatively high level of unemployment of 9.7% in 2010 and 10% in January 2012 (EU calculation, see Eurostat press release March 2012). In addition, the trade balance of goods has gradually deteriorated during the last decade, highlighting the challenges of French companies in terms of cost and non-price competitiveness.

As a consequence, the government is trying to limit the growth of social expenditure by tightening further the rules for access to pension and by reducing the public coverage of health expenditure. As for long-term care the announced reform implying further expenses it has been postponed. However since autumn 2011, France has entered a specific political period, with the forthcoming Presidential election (late April early May 2012). Various announcements have been made, which do not announce structural transformation of the social protection system, except in its financing, with the adoption of a "Social VAT" – an increase of 1.6% for VAT –, in exchange of a decrease of social contribution paid by the employers (adopted in late February 2012), but to be adopted in October 2012, i.e. after the election (and thus submitted to the result of these elections).

2.2 Pensions

2.2.1 The system's characteristics and reforms

The French pension system has been overwhelmingly financed on a pay-as-you-go (PAYG) basis and is characterised by a relatively high degree of occupational fragmentation.

The *régime général* covers all private-sector wage-earners (around 60% of the workforce) and provides a basic defined-benefit pension which replaces a maximum of 50% of the 25 years of highest pay. *Régime général* contributions as well as the wages that serve as a reference for this benefit are calculated only up to a "social security ceiling" – set at EUR 3,031 per month in 2012. The *régime général* is complemented by non-statutory but mandatory supplementary PAYG pension schemes (*régimes complémentaires obligatoires*) established by collective agreements. The ARRCO (*Association pour le régime de retraite complémentaire des salariés*) covers all private-sector employees, whereas the AGIRC (*Association générale des institutions de retraite des cadres*) covers only "cadres", i.e. white-collar workers. These are hybrid schemes in which benefits are tightly linked with the amount of contributions paid into the system. Up to the social security ceiling, all private-sector employees (including cadres) have to pay contributions to the ARRCO (with a rate of 7.5% of the gross wage) in addition to the

contributions paid for the statutory *régime general* (with a rate of 14.95%)[1]. Above the social security ceiling and up to 8 times its amount, "cadres" pay contributions (of 20.3%) to the AGIRC. Employees who are not cadres pay contributions to the ARRCO (with a rate of 20%) up to 3 times the social security ceiling.

Civil servants and employees of public-sector companies are covered by special schemes and receive relatively generous defined-benefit pensions which offer a maximum of 75% of the wages earned during the last six months of the worker's career.

To be eligible for a pension, employees need to reach the minimum statutory retirement age. Except for some special schemes, the minimum retirement age was set at 60 years and 4 months beginning of 2012 and is due to gradually increase to 62 years by 2017. This gradual increase in the retirement age is the result of reforms enacted in November 2010 and November 2011.

A full pension is only provided to those workers who have reached the minimum duration of insurance. In most schemes, this duration was set at 41 years in 2012 and is due to increase to 41.5 years for workers born in 1955 and later. Since a reform enacted in 2003, the minimum duration of insurance is raised in line with increases in life expectancy.

For those workers who have attained the minimum retirement age but who decide to retire before reaching the minimum duration of insurance, benefit levels are lowered proportionally to the number of missing trimesters (*décote*), i.e. by 1.25% per missing trimester. Symmetrically, when people have contributed longer than required, they get a pension bonus (*surcote*) of 1.25% for each additional trimester. However, a full benefit is offered − whatever the duration of insurance − from 65 years and four months (to be increased to 67 years for workers born in 1955).

Workers with long careers – i.e. those who started working before age 18 and who have a long contribution record (at least the minimum duration of insurance) – can retire early (age 56 at the earliest) and draw a full pension from the *régime général* (and aligned schemes including in the *régimes complémentaires obligatoires*). This possibility was introduced with the 2003 pension reform, but eligibility rules will gradually become stricter following the 2010 reform (see below).

Next to these contributory schemes, the French pension system offers two types of statutory minimum pensions. One is a non-contributory minimum pension (*minimum vieillesse* or *allocation de solidarité aux personnes âgées*) for which all residents above the age of 65 are potentially eligible after a means test. Its amount was EUR 742.27 per month for an individual living alone in 2012. The second one is a minimum pension for a full career (*minimum contributif*) which is offered only to workers who have reached the minimum contribution period. Its amount was EUR 608.15 per month in the *régime général* in 2012, but this amount is always topped up by the benefits accrued in the AGIRC and ARRCO schemes.

The extensive role of PAYG schemes in France had until recently left little room for the development of funded pension plans, although such schemes have traditionally benefited from tax incentives. The 2003 reform introduced two new defined-contribution pension products whose coverage has been expanding ever since. These are respectively voluntary personal pension plans (PERP – *Plans d'épargne retraite populaires*) and voluntary occupational pension plans (PERCO – *Plans d'épargne retraite collectifs*).

[1] An additional contribution of 1.7% has to be paid on the whole gross salary, even above the social security ceiling.

Given its impact on the financing of the pension system, increasing labour market participation of older workers has become a government priority over the past few years. Most public early retirement schemes and disincentives to work longer have been gradually phased out. However, early retirement for workers with long careers continues to exist and the 2010 reform introduced a right to retire at the age of 60 instead of the age of 62 for workers who have a partial (20%) incapacity to work.

2.2.2 Debates and political discourse

In 2011, political debates about the evolution of the pension system have been dominated by parametric changes in the AGIRC and ARRCO supplementary PAYG schemes and by the acceleration of the increase in the statutory retirement age enacted in 2010. Due to the upcoming presidential and legislative elections, political parties have continued arguing about increases in the retirement age. However, discussions about the possible unification of the French pension system have remained confined to expert circles.

The 2010 reform of statutory pension schemes had implications for the AGIRC and ARRCO schemes, i.e. the supplementary PAYG schemes managed by the social partners. In March 2011, the social partners have negotiated a new agreement on these schemes[2]. The social partners have agreed: to align the retirement age in the supplementary schemes with that of statutory schemes and to harmonise the "rate of return"[3] in the AGIRC with that of the ARRCO. In 2011, the rate of return was set at EUR 6.59 for each EUR 100 paid into ARRCO and 6.70% in AGIRC. It had been regularly reduced by the social partners over the last two decades. However, with the new agreement, the social partners have decided to stabilise it between 2012 and 2015. The agreement also changed pension bonuses for mothers in the two schemes. While the AGIRC traditionally offered higher bonuses than ARRCO, the agreement harmonised these bonuses within the two schemes. Women with three children will get a bonus of 10% in both schemes. The bonus will be capped to EUR 1,000 per year and will be counted according to the new regulations only for employment after December 31st 2011. Employers from the MEDEF (France's main employers' association) also wanted to decrease widow(er)s' pensions by diminishing the theoretical replacement rate from 60% to 54% but abandoned the idea due to unions' opposition[4].

The agreement has been signed by employers and by three unions: the CFDT[5], FO and the CFTC. Two unions have refused to sign: the CGT and the CFE-CGC[6]. The CGT which traditionally had close links with the communist party refuses to condone the increase in the retirement age. Although the CFE-CGC was not opposed in principle to an increase in the retirement age, the cadres' union protested against the agreement[7] and even filed a suit against it in the *Conseil d'Etat* and the *Tribunal de Grande Instance de Paris*[8], mainly because, by harmonising rules between ARRCO and AGIRC, it opens the door for a future merger between

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2 Les Echos, Age de départ, niveau des pensions, bonifications pour enfants: ce que dit le projet d'accord, March 21st, 2011.

3 This indicator is used by the social partners to assess the effects of changes in indexation mechanism. The formula is: value of the point/(price of the point)*(call-up contribution rate). For more details see NACZYK Marek and PALIER Bruno (2010), Complementing or replacing old-age insurance, Recwowe working paper, 8/10, http://www.socialpolicy.ed.ac.uk/__data/assets/pdf_file/0018/44082/REC-WP_0810_Naczyk_Palier.pdf.

4 Les Echos, Agirc-Arrco: le Medef renonce à réduire les pensions des veufs et veuves, March 18th 2011.

5 http://www.cfdt.fr/rewrite/nocache/article/32892/salle-de-presse/communiques/communique-de-presse-n%C2%B022-du-28-mars-2011.htm?idRubrique=8990.

6 Les Echos, CGT et CGC prêtes à s'opposer à l'accord Agirc-arrco, March 29th 2011.

7 For position of the union, see documents posted on its website: http://www.cfecgc.org/ewb_pages/div/Regimecomplementaire.php.

8 See http://www.cfecgc.org/e_upload/pdf/recourscfecgcagirc.pdf.

the two schemes. The cadres' union has traditionally presided over the institution. Coverage by AGIRC directly defines the "cadre" status. Should the ARRCO and the AGIRC be merged, the specificity of the "cadre" status could be lost, and this could affect membership in the union. Beyond a possible merger between the two schemes, the agreement could also be interpreted as a step towards the introduction of a NDC system.

The second important change that has marked 2011 was the acceleration of the increase in the statutory retirement age already enacted in 2010. In November 2011, the right-wing Fillon government announced it would increase the minimum retirement age to 62 years by 2017 instead of 2018, as planned by the 2010 reform. The increase was enacted in December 2011 as part of the bill on the financing of social security in 2012 (*Loi de Financement de la Sécurité Sociale pour 2012- LFSS 2012*[9]). This measure was announced following Moody's, a rating agency, made known at the end of October that within it would reassess – and possibly downgrade – France's credit rating[10]. The government's decision to accelerate the increase in the retirement age was thus clearly a reaction to this threat, although it did not prevent the Standard and Poor's agency to cut France's rating beginning of January[11]. Trade unions criticised the government for showing "disregard" by not consulting the social partners beforehand[12].

Although the measure was announced in haste, the idea of further increases in the retirement age had already been signalled several times by the government since the beginning of 2011. In January 2011, Prime Minister François Fillon declared that EU countries should ultimately aim to harmonise statutory retirement ages[13]. Beginning of February, the French and the German governments signalled their willingness to go in that direction, when they announced a "pact for the competitiveness of Europe"[14]. Fillon reiterated his plans for convergence in September 2011, when he declared that France should aim to increase the retirement age to the same level as in Germany[15].

In fact, President Nicolas Sarkozy and the right-wing UMP (*Union pour un Mouvement Populaire* – Union for a Popular Movement) party have based much of their campaign for the 2012 presidential and legislative elections on the idea that France should follow the German economic model and introduce structural reforms as the ones introduced for example at the beginning of the 2000s by Gerhard Schröder, including increases in the retirement age[16]. On the other side of the political spectrum, the main opposition party – i.e. the Socialist Party (Parti Socialiste) has remained split on the issue of the increase in the retirement age, ever since the debate around the 2010 reform[17]. In an initial programme for the 2012 election that was presented in spring 2011, the Socialist Party announced it would bring the statutory retirement age back to 60 years, as it was before the 2010 reform[18]. However, in December 2011, the party's candidate for the presidential election, François Hollande, said that he would re-establish retirement at age 60 only for those who would start working at age 18 and would be insured for at least 41 years, thereby making rules more stringent than they were before the

9 http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000025005833&dateTexte=&categorieLien=id#.
10 Les Echos, "Fillon annonce 18,6 milliards d'euros d'économies en 2012 et 2013", November 7th 2011.
11 Financial Times, "S&P downgrades France and Austria", January 14th 2012.
12 Le Figaro, "Le président de la CNAV proteste contre les nouvelles règles", November 9th 2011.
13 Les Echos, "Fillon relance le débat sur la convergence sociale européenne", January 7th 2011.
14 Le Monde, "Berlin et Paris s'entendent pour proposer un 'pacte de compétitivité", February 4th 2011.
15 Les Echos, "Fillon veut faire converger la France et l'Allemagne", September 23rd 2011.
16 Le Figaro, "La carte allemande", January 31st 2012.
17 Les Echos, "Martine Aubry fait machine arrière sur l'âge légal", January 27th 2010.
18 http://www.parti-socialiste.fr/static/11519/le-projet-socialiste-pour-le-changement-en-2012-adopte_0.pdf, p. 34.

2010 reform. This compromise had in fact been suggested to the candidate by the CFDT union[19]. According to the Socialist Party and the independent think tank *Institut Montaigne*, the measure would cost EUR 1 billion during the first year of its implementation[20]. The Socialist Party would finance the measure by increasing employees' and employers' social contribution rates by 0.1 percentage points per year.

While the issue of the retirement age has been political very salient in the pre-election period, the debate around a "systemic reform" and the introduction of a unified pension system in France has been largely clouded. A search on the *Lexis Nexis* database shows that, between January 1st 2011 and mid-February 2012, only 13 articles included the keyword "réforme systémique" and "retraite" (i.e. pension) in a selection of mainstream newspapers (Le Monde, Les Echos, La Tribune, Le Figaro). This result clearly shows that this important debate for the future of the French pension system remains confined to expert circles. The 2010 reform bill clearly stated that a debate about a systemic reform will have to be held in 2013 and will have to include a discussion about the introduction of a unified NDC or point system. Politicians have not seized the opportunity of the 2012 elections to put it on the public agenda.

On their side, experts and the social partners continue to prepare themselves for that debate[21]. Many trade unions (i.e. especially the CGT, the CFE-CGC and Force Ouvrière) publicly oppose the introduction of such a reform[22]. The CFDT continues to be one of its main proponents and has tried to convince political actors to adopt its vision of the reform. Nevertheless, beginning of January 2012, the CFDT's general secretary, François Chérèque, has voiced his disappointment about the fact that the Socialist presidential candidate, François Hollande, who had initially expressed support for a systemic reform had changed his position on the issue. Chérèque said that "Today, [the candidate] who is closest to our position on the issue is François Bayrou [i.e. a centrist candidate]"[23]. In the meantime, France's main employers' association, the MEDEF, has expressed their official support for a systemic reform in an e-book published by its president Laurence Parisot in order to give her organisation more influence in the public debate for the presidential election[24].

2.2.3 Impact of EU social policies on the national level

As a specific policy tool, the Open Method of Coordination in the field of pensions is very rarely mentioned in the French public debate. However, comparisons with other European countries on indicators such as retirement age, employment rates of elderly workers, the level of non-wage-labour costs appear very frequently in the media and are also often used by the participants in the pension debate. The most striking example of the use of foreign examples is the fact that the right-wing Fillon government has been constantly referring to the German model and to the idea of a convergence in the countries' pension systems (and more

[19] Les Echos, "Retraite à 60 ans: la CFDT offre une porte de sortie au PS", November 15th 2011.
[20] Les Echos, "Retraites: le projet du PS coûterait 1 milliard en 2012, 5 milliards en 2017", December 19th 2011.
[21] See for example reports published by the Conseil d'Orientation des Retraites on compensation mechanisms within existing schemes and on the situation of the polypensionnés (i.e. pensioners who draw their pension from several statutory pension schemes): CONSEIL D'ORIENTATION DES RETRAITES (COR), « Retraites: la situation des polypensionnés - Neuvième rapport ». Paris : COR, September 2011 http://www.cor-retraites.fr/article403.html; CONSEIL D'ORIENTATION DES RETRAITES (COR), « Retraites: la rénovation des mécanismes de compensation - Dixième rapport ». Paris : COR, October 2011 http://www.cor-retraites.fr/IMG/pdf/doc-1583.pdf.
[22] See e.g. Le Figaro, "Jean-Claude Mailly: 'La logique d'austérité est suicidaire'", August 31st 2011.
[23] Les Echos, "Pas de consigne de vote, mais une CFDT offensive dans le débat présidentiel", January 25th 2012.
[24] Cf. http://besoindaire.com/pdf.html. See Le Monde, "Le Medef privilégie la réduction des dépenses publiques", February 15th 2012.

specifically their retirement ages). However, it remains difficult to assess to what extent the OMC as such contributes to it.

Broadly speaking, recent reforms have been in line with the goals set by the EU 2020 strategy, the 2011 Annual Growth Survey and the country specific recommendations of the Commission and the Council published in July 2011. With the 2010 reform and its November 2011 decision to increase its pace, France's priority has been to ensure the long-term sustainability of the pension system by increasing the statutory retirement age. The government has also refrained from re-introducing any public early retirement programmes during the economic crisis. The future of the system is being constantly monitored and discussed within the *Conseil d'Orientation des Retraites*, which gathers government officials, the social partners and other stakeholders.

2.2.4 Impact assessment

The *financial sustainability* of public pension schemes has continued to be weakened by a low growth rate and a steady increase in the number of pensioners. However, the deficits have been reduced in 2011 compared to previous years due to an increase in the total wage bill. According to projections published by the *Commission des comptes de la sécurité sociale* in September 2011 (and updated in November 2011 to take into account the *projet de loi de financement de la sécurité sociale 2012*, i.e. project on the bill on the financing of social security for 2012), the deficit of the *régime général* pension scheme (i.e. the scheme covering private-sector employees) was to reach EUR 6.0 billion in 2011 and 5.8 billion in 2012 compared to EUR 8.9 billion in 2009[25]. The projection for 2012 is based on the hypothesis that economic growth will reach 1% and that the total wage bill (*masse salariale*) will increase by 3%. A large part of the decrease in the deficit in 2012 should be due to the increase in the minimum retirement age passed in November 2010 and accelerated in December 2012.

In the National Reform Programme it submitted in spring 2011[26], the French government tabled on the fact that the 2010 reform bill will reduce the public deficit by 0.5% of GDP by 2013 and 1.25% by 2020, and as a result lead to a reduction of public debt by 10% of GDP in 2020 (p. 13). This would mean an improvement in the financial sustainability of the pension system.

The supplementary PAYG schemes have also continued to be affected by the crisis. According to the financial results and projections the schemes published in June 2011[27], the ARRCO posted a "technical" deficit of EUR 0.14 billion in 2010 (compared to a surplus of EUR 900 million in 2009), but due to transfers of EUR 1 billion towards the AGIRC and because of the use of assets from its buffer fund (EUR 1.5 billion) it reached a total surplus of EUR 355 million. The deficit (including transfers towards the AGIRC) was due to increase to EUR 1.6 billion in 2011 and 2.5 billion in 2012[28]. At the AGIRC, the technical deficit reached 2.5 billion in 2010 compared to 2 billion in 2009. The deficit was reduced to a total deficit of 709 million, as the result of transfers of 1 billion from the ARRCO and the use of 0.79 billion of assets from the AGIRC buffer fund. The deficit (including transfers from the ARRCO) was due to reach 1.7 billion in 2011. However, the increase in the minimum retirement age should improve the financial situation of the two schemes, especially from 2014 and 2015[29].

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[25] COMMISSION DES COMPTES DE LA SECURITE SOCIALE, « Les comptes de la sécurité sociale : Résultats 2010, Prévisions 2011 et 2012 » http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics//114000583/0000.pdf p. 7.

[26] http://ec.europa.eu/europe2020/pdf/nrp/nrp_france_en.pdf.

[27] http://www.agirc-arrco.fr/fileadmin/agircarrco/documents/presse/presse2011/cp_29062011_arrco.pdf; http://www.agirc-arrco.fr/fileadmin/agircarrco/documents/presse/presse2011/cp_29062011_agirc.pdf.

[28] Les Echos, "l'Agirc et l'Arrco creusent leurs deficits", June 30th 2011.

[29] Les Echos, "l'Agirc et l'Arrco creusent leurs deficits", June 30th 2011.

Regarding the *adequacy of pensions*, Eurostat indicators show that, in comparison with other European countries, the French pension system has continued to be relatively successful at ensuring a high level of income maintenance of retired workers and at preserving a low level of poverty among pensioners. While in other countries, the elderly (65+) have generally a lower relative median income than the rest of the population (0-64 years – ratio of 88 in EU-27 countries), in France this is not the case (ratio of 100). France also scores better than most of its counterparts on different indicators of poverty among people aged 65 and more, such as the at-risk-of-poverty-rate (9.7% compared to 15.9%), the at-risk-of-poverty-or-social-exclusion-rate (12% compared to 19.8%) and severe material deprivation of people (3.4% compared to 6.4%). All three indicators also show that pensioners have a lower risk to be in poverty than the rest of the population. Although this is the case in most European countries, the difference in these indicators is more pronounced in France. The relatively low level of poverty among the elderly in France can be attributed to the fact that current pensioners have benefited from a PAYG system that traditionally offered generous income maintenance and has included two types of minimum pensioners (*minimum vieillesse* and *minimum contributif*). Current pensioners also belong to cohorts which benefited from relatively stable employment during their working careers.

However, indicators such as the at-risk-of-poverty-rate and the at-risk-of-poverty-or-social-exclusion-rate show that people aged 75 or more are much more likely to be poor than people aged 65 (respectively 12% compared to 9.7% and 14% compared to 12%). Moreover, there is a significant gap between levels of poverty among men and women (e.g. at-risk-of-poverty-rate of 8.0% for men aged 65 years or more compared to 10.8% for women). The high level of poverty among pensioners aged over 75 years has to do with the high number of older women who have had very uneven contribution records during their working lives and also had lower wages. The same reasons largely account for the gender gap regarding poverty[30].

It seems that no new official projections of future replacement rates have been carried ever since the publication of the 8th report of the Conseil d'Orientation des Retraites[31], which did not include projections of replacement rates as such but provided an indicator of the evolution of the relative purchasing power of old-age pensions compared to that of the average wages in the economy[32]. However, the Conseil d'Orientation des Retraites currently works on possible adaptations to the way these projections are made[33]. Adaptations could include the introduction of more realistic profiles of the "typical" occupational trajectories that are taken into account in the projections[34]. Recent research has shown the detrimental effect for the level of pensions of periods of unemployment, part-time work and inactivity[35].

Given projected decreases in the replacement rates of public pensions, the role of private funded pension schemes is generally thought to become more important in the future. Private

[30] See e.g. DREES (2011) *Les retraités et les retraites en 2009*. Paris: Direction de la recherche, des études, de l'évaluation et des statistiques (coll. Etudes et statistiques), pp. 84-85.

[31] CONSEIL D'ORIENTATION DES RETRAITES, "Retraites: perspectives actualisées à moyen et long terme en vue du rendez-vous de 2010", Huitieme rapport, April 2010 (see: http://www.cor-retraites.fr/article368.html).

[32] See PALIER Bruno, NACZYK Marek, MOREL Nathalie, "Annual National Report 2011: Pensions, Healthcare and Long-Term Care: France", pp. 11-12.

[33] http://www.cor-retraites.fr/article406.html ; http://www.cor-retraites.fr/article399.html.

[34] E.g. BLANCHET Didier, BUFFETEAU Sophie, CRENNER Emmanuelle, LE MINEZ Sylvie, « Le modèle de microsimulation Destinie 2: principales caractéristiques et premiers résultats », Economie et Statistique, Economie et Statistique, nr 441-442, October 2011, http://www.insee.fr/fr/ffc/docs_ffc/ES441F.pdf.

[35] EL MEKKAOUI DE FREITAS Najat, DUC Cindy, BRIARD Karine, MAGE Sabine, LEGENDRE Bérangère, "Aléas de carrière et pensions de retraite", Economie et Statistique, nr. 441-442, October 2011, http://www.insee.fr/fr/ffc/docs_ffc/ES441H.pdf.

pensions have traditionally played a very marginal role in the income packages of pensioners, due to the relative generosity of public schemes. But research shows that coverage of private plans has continued to increase. Art. 83 defined-contribution plans[36] are the most prevalent form of occupational funded plans. In total, they covered somewhere between 3.7 and 4 million active private-sector workers[37] in 2009. Despite a lack of data, art. 39 defined-benefit plans were believed to be much less widespread and, like in other countries, were being progressively closed for new entrants. Among current pensioners, only about 130,000 people received a pension from an art. 39 schemes, while 357,000 had an annuity from an art. 83 plan[38]. PERCO covered 1.6 million private-sector workers by 2009[39], although only 557,000[40], i.e. 25% of them actively contributed to them. Finally, the development of funded pensions has been also driven by the PERP which was introduced from 2004 and had attracted 2 million participants by 2009.

2.2.5 Critical assessment of reforms, discussions and research carried out

With a two-tier structure in the private sector (régime général and régimes complémentaires) and relatively generous final-salary schemes in the public sector, the French pension system has so far been able to maintain workers' income in old-age. The existing system has also had mechanisms that have been relatively effective at preserving a low level of poverty among pensioners. Thus, workers with full careers but with low incomes have benefited from the *minimum contributif*. Workers with short working careers have benefited from the possibility to get a full pension at age 65 (to be increased after the 2010 reform) despite not having reached a full contribution record. Finally, the *minimum vieillesse* – i.e. the means-tested non-contributory minimum pension – has been the mechanism of last resort to protect pensioners from poverty.

Perhaps the biggest challenge in the existing system regarding poverty is the difference in benefits between the oldest pensioners (75+) and younger ones. One reason for this difference has to do with the fact that the oldest cohorts of pensioners include many women who had very short working careers. Another reason has to do with the changes in the indexation and the valorisation of pensions, which since 1993 have been based on price inflation instead of wage inflation. As a result, the purchasing power of pensions diminishes with time.

As evidenced by existing projections of future replacement rates, the adequacy of pensions will become a more important problem in the long run. Over the last two decades, pension reforms have increased the minimum contributory period required to get a full pension. Benefit levels are also increasingly linked to contributions. Official projections[41] have so far assumed that future pensioners will have a 40 year contribution record at retirement. This seems relatively unrealistic for a growing proportion of workers who enter the labour market relatively late or are employed under temporary contracts. A positive point is that as part of the discussions

[36] For a presentation of the different types of private plans, see NACZYK, Marek and PALIER, Bruno, "France: Promoting Funded Pensions in Bismarckian Corporatism?" In Bernhard EBBINGHAUS (Ed.), The Varieties of Pension Governance. Pension Privatisation in Europe. Oxford: Oxford University Press 2011.

[37] DREES (2011), *Les retraités et les retraites en 2009*. Paris: Direction de la recherche, des études, de l'évaluation et des statistiques (coll. Etudes et statistiques). http://www.sante.gouv.fr/IMG/pdf/retraites2009-3.pdf, p. 99.

[38] DREES (2011), *op. cit.*, p. 103.

[39] COUR DES COMPTES (2011) *Rapport sur l'application des lois de financement de la sécurité sociale*. Paris: Cour des Comptes. http://www.ccomptes.fr/fr/CC/documents/RELFSS/Rapport_securite_sociale_2011.pdf p. 355.

[40] DREES (2011) *op. cit.*, p. 99.

[41] CONSEIL D'ORIENTATION DES RETRAITES, "Retraites: 20 fiches d'actualisation pour le rendez-vous de 2008", *Cinquième rapport*, November 2007.

about the introduction of a unified NDC pension system, the *Conseil d'Orientation des Retraites* seems to have taken this issue seriously and is currently studying the possibility of making simulations with more realistic typical cases of individuals. How non-contributory periods (e.g. for maternity leave, sickness leave or unemployment) are taken into account in the pension system is likely to be a crucial issue in the 2013 debate about a systemic pension reform.

A crucial issue both for the adequacy of pensions and for their financial sustainability remains the low labour market participation of older workers. France did not reach the Lisbon strategy target of an employment rate of 50% for workers aged 55-64. This indicator reached 39.7% in 2010 (up from 38.9% in 2009 – cf. Eurostat Labour Force Survey). However, when one disaggregates this indicator and examines separately the employment rates of workers aged 55-59 and 60-64, one can see that France has been underperforming on the second indicator (17.9% compared to 30.5%). The real challenge for France thus lies in increasing employment among workers aged 60-64. Efforts made by the government to suppress public early retirement schemes as well as the increase in the statutory minimum retirement age introduced by the 2010 reform may contribute to tackling this issue. However, this will depend on whether these measures will have a significant cognitive impact on employers. There is still uncertainty as to whether employers' attitudes towards older workers have really improved.

In the current context of austerity, it is quite unlikely that French policy-makers will try to expand the generosity of the PAYG system. It remains to be seen what the result of the 2013 debate about a "systemic" reform will be. If policy-makers decide to replace existing schemes with a single nation-wide NDC scheme, this will give rise to serious technical debates about what should be done with non-contributory benefits (i.e. bonuses for non-contributory periods and minimum pension arrangements). Policy-makers should make sure that existing mechanisms of solidarity in the system are preserved if not reinforced. A question that could be asked is whether the PAYG system should replace workers' income in old age up to 8 times the social security ceiling as is currently the case in the AGIRC[42]. A solution that could be envisaged in a unified NDC scheme would be to suppress the social security ceiling for the payment of contributions and to reduce the level at which benefits are replaced to 4 or 6 times of the current social security ceiling.

Apart from reforms in the PAYG system, another option to improve the adequacy of pensions would be to increase coverage of occupational pension plans. So far, these schemes have been mostly based on voluntarism. Workers' contributions to PERCO schemes (i.e. schemes established at the company or industry level through collective agreements and institutionally linked to profit-sharing schemes - *participation*) have been entirely voluntary. Following the 2010 reform, 50% of the bonuses that workers get through profit-sharing schemes (*participation*) should automatically be transferred to their PERCO, unless they decide otherwise. The problem is that profit-sharing schemes are far from covering all French workers. In 2009, approximately 44.7% of French workers benefited from profit-sharing (*participation*)[43]. These are overwhelmingly workers employed in large firms, which means that workers employed in small firms will be at a disadvantage. More should be done to encourage participation of workers employed in small firms in profit-sharing schemes and in the PERCO. Perhaps, policy-makers should develop a regulatory framework that would

[42] EUR 3,031 per month in 2012. For more information, see e.g. http://www.urssaf.fr/employeurs/baremes/baremes/plafonds_des_salaires_par_periodicite_de_paie_01.html (retrieved on 06.02.2012) or Naczyk and Palier (2010) Complementing or replacing old-age insurance, Recwowe working paper, 08/10, p. 20.

[43] AMAR Elise, "Participation, intéressement et épargne salariale en 2009: un recul des montants distribués", *Dares – Analyses*, nr. 63, August 2011.

encourage the creation of industry-level pension funds with mandatory contributions, as has been done in Belgium with the 2003 Vandenbroucke reform.

2.3 Health Care

2.3.1 The system's characteristics and reforms

System characteristics[44]

In France, the supply of health care is partially private (primary or ambulatory health care, certain hospitals or clinics – around 20% of the beds), and partially public (80% of hospital beds, but very few primary health care centres). It guarantees the patient's free choice of doctor, as well as the status of the liberal practice of medicine. In France, ambulatory care includes both general practitioners and specialists. 49% of the doctors in the ambulatory care sector are specialists. The compartmentalisation between ambulatory and hospital medicine is very marked, with the risks of a lack of coordination, of redundancy or even of contradictions in treatment. The number of hospital beds remains high in France.

Expenses are mainly assumed by the different health insurance funds and financed by social contributions and a specific tax, CSG (*Contribution Sociale Généralisée*). It is financed by 19 basic sickness insurance funds, among which the CNAMTS (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés* – National Sickness Insurance Fund for the Salaried Workers) is the most important one covering 80% of the population. Basic sickness insurance funds are compulsory but do not cover all the costs, and are thus complemented by mutual health insurances, private and facultative (85% of the French population has one).

To qualify for sickness insurance, the insured person must have worked a minimum number of hours in salaried employment during the period preceding the treatment. Each individual is supposed to be registered to the health insurance fund corresponding to his occupation. The coverage has been extended in 1999 to everybody by the creation of the CMU (*Couverture Maladie Universelle* – Universal Sickness Coverage), an income-tested health insurance. Sickness insurance covers the insured and his/her dependants (*ayants-droits*: spouse or common-law husband or wife, and children under 16, or 20 if they are still in full-time education or are disabled).

Cash benefits (*prestations en espèces* or *indemnités journalières*) are intended to compensate for loss of earnings because of inability to work due to sickness. They are paid as from the third day of sick leave (*délai de carence*) for a maximum period of three years. The *régime général*'s sickness cash benefits amounts to 50% of employees' gross wages up to a 'ceiling', and are regularly uprated (EUR 3,031 per month in January 2012). The level of wage replacement is supplemented either by the employers (depending on the result of collective bargaining) or by the complementary schemes (mainly *Mutuelles*).

Benefits in kind (*prestations en nature*) are delivered by the sickness insurance schemes through reimbursement for medical and pharmaceutical expenses, dental treatment, dentures, artificial limbs and so forth, and directly for hospital expenses. In ambulatory health care, provision is delivered on the basis of fee-for-service (*paiement à l'acte*). The fees for medical care and treatment are decided through agreement negotiated between the social security agencies (or funds) and medical practitioners' professional organisations.

[44] This presentation of the system's characteristics is based on: Jean-Jacques Dupeyroux, Michel Borgetto, Robert Lafore, 2009, "Droit de la sécurité sociale", Paris, Dalloz-Sirey - Collection Precis dalloz (16th edition) and Bruno Palier, 2010, *La réforme des systèmes de santé*, Paris, PUF, Collection Que sais-je? (fifth edition).

For medical and pharmaceutical expenses, the insured person initially settles the bill out of his/her pocket and is then partly reimbursed. Medical care and treatment are reimbursed at up to 65% of the charge in average. The remainder (co-payment), known as the *ticket modérateur*, varies between 20% and 60% of the total expense; it has to be paid by the patient. This system is supposed to encourage people to moderate their demands. However, complementary insurance *(Mutuelles)* very often reimburses the cost of the *ticket modérateur*. Today, 85% of people pay for a complementary health care insurance. A further 7% of the French population gets an income tested free complementary insurance (*Couverture Maladie Universelle Complémentaire*).

When inpatient care is required, the insured person pays a daily fixed amount to cover the cost of food and accommodation (*forfait hospitalier* = EUR 18 per day in 2012). Since 2008, public hospitals receive funding based on their activity (*tarification à l'activité*) from the Regional Hospital Agencies (*Agence Régionale de l'Hospitalisation)* and *the Sécurité sociale* to cover their medical expenses.

Reforms

Since the beginning of the 1970s, in France, health care expenditures have increased much faster than the economy grew. The first main response to this trend has not been retrenchment, but has long been to increase social contribution paid to health insurance funds. By the mid 1980s, increasing the social contribution appeared an economic dead end, and attempts were made to limit the growth of health insurance expenditure and to reduce the deficits of the health insurance funds. Cost containment policies in the French health insurance system have two main aspects: the introduction of a capped budget for health expenditures and a decrease in health risk coverage.

In the 1980s conventional negotiations between the government and medical professions took place, the Minister for Social Affairs tried to impose a 'global volume envelope' in order to try to link the growth of expenditure in ambulatory care to economic growth. This goal was accepted by the Sickness insurance fund (CNAMTS) which then negotiated with the medical unions in exchange for the creation of the so-called "sector 2" (*secteur 2*). Doctors in this sector are able to charge higher fees than those reimbursed by the sickness funds (on "over-billing", see next sections), the difference being paid directly by the patient. But only one medical union accepted this system. The biggest union was clearly against it. Because of this opposition, the global volume envelope was never implemented. In 1983 a global budget for hospitals was introduced in an attempt to control costs in this sector.

After the 1988 presidential election the new government, headed by Michel Rocard, wanted to negotiate regulation. This strategy also corresponded to a reorientation of regulation away from a financial to a medicalised logic, based on the medical evaluation of therapeutic activities. It was only introduced in the new convention signed in October 1993. An objective of cost growth was fixed (3.4%), as were "medical references". If a doctor did not conform with these therapeutic norms he could be penalised. But these changes were limited. The main point is that doctors could not be penalised automatically if the aimed fixed rate was overshot.

The limited effects of such negotiated cost containment policies in France explain the introduction of a capped budget for all health insurance expenditures in the 1996 reform (*plan Juppé*) which imposed an annual vote on national health spending objectives (ONDAM – *Objectif National de Dépenses d'Assurances Maladie* – National Target for Sickness Insurance Expenditures) on every sector of the health insurance system (ambulatory and hospital care).

Meanwhile, the public coverage of health expenditures has decreased between 1980 and 2012, from 79.4% to 75.5% in general, but more specifically on ambulatory care expenditure (see

below), because of the reduction of reimbursement rates for patients and of the creation of direct patient co-payments for health care services (creation of the hospital flat rate co-payment in 1982, increases in patients' co-payment for medical consultation, drugs and medical analysis). The 2004 reform again raised the co-payment for patients: it planned to increase the hospital fee by EUR one per year until 2007. It has been increased again in 2010, up to EUR 18 per day. The 2004 reform also introduced a new EUR one co-payment for medical consultation that cannot be reimbursed by the Mutual insurances (called *franchise*), and it implemented de-reimbursement of drugs. Unless you are under acute care (and then almost fully covered), the level of patient co-payment was raised to 30% for medical consultation, to 40% for drugs and to 20% for hospitalisation. In 2008, new *franchises* have been created on drugs (EUR 0.50 per box), biological exams and transportation (EUR two per act and per transport).

If patients have to pay more out of their pocket, doctors have benefitted from increase in the value of their fees. In 2002, France's general practitioners (GPs) actually went on strike for higher fees (EUR 20 per consultation). The raising of the fees was accepted by the new Minister for Health, at a time when the deficit of the health insurance system was already growing! Since then, the fees for doctors have been regularly increased, to reach the level of EUR 23 per consultation for generalists in 2012, and EUR 27 for the specialists in 2012.

Beyond trying to control costs, the governments have also tried to reorganise the French health care system. In 2004 a new law on health insurance was voted by the French Parliament. This reform embodied no new constraint for doctors (for their activity, for prescriptions or for installation) and gave specialists the right to get higher fees when patients consult them directly, without being addressed by a GP. The main effort was again being asked from patients, in the form of raising co-payments and taxes, and asking them to choose a *médecin traitant* (regular treating Doctor) and see him/her first before doing anything else. All French insured persons now have to choose their *médecin traitant* (it is usually a GP, but it can be a specialist). It will cost them more if they consult a specialist directly without being addressed by their main GP. In 2012, the health insurance funds was only reimbursing 30% of the consultation fees when the visit to doctor was not authorised by the *médecin traitant*.

In the hospital sector, one sees trends of managerialisation of the hospital sector and the creation of new state agencies. In France this managerialisation process began with the 1991 law. The purpose of the law was to make hospital regulation take into account the real activity of hospitals (importing into France the "Diagnosis Related Group" method from the US). With this reform each hospital's budget was to depend upon an evaluation of its activity and its prospective development, both to be negotiated with the State. Since the beginning of the 1990s, two new tools for evaluation have been introduced: the "Programme of Medicalised Information Systems" (geared to evaluating the activity of each hospital and to introducing payment systems based on diagnosis related groups) and "Medical References" for ambulatory care (containing therapeutic norms and norms for prescription). The 1996 reform further promoted and generalised the evaluation of therapies in the health insurance system with the creation of a National Agency for Accreditation and Evaluation in Health (ANAES), recently incorporated within the new top authority on health (*Haute Autorité en Santé*) created in 2004. Regional hospital agencies (*Agences Régionales d'Hospitalisation*) have also been created to distribute budgets between hospitals, based on an evaluation of the performance of every hospital. These agencies also have the right to close inefficient hospitals after an accreditation enquiry.

The law entitled *Hôpital, patients, santé, territoires* (Hospital, patients, health and territories - HPST), presented by the government at the end of 2008 and was finally adopted in July 2009 is a continuation of this decentralisation and regionalisation trend, as well as managerialisation of hospital trends. This law lead to the creation of Regional Health Authorities (*Agences*

Régionales de Santé) as of 1 April 2010, in charge of directing and coordinating health policies at the regional level, and to give more power to the hospital directors (this latter point being fiercely criticised by the medical profession, and being progressively amended by the government during parliamentary debates). The idea is to reinforce the power of the hospital director, in order to better support a coherent policy and a better articulation between the various establishments (public and private) on the same territory. In the same direction, Regional Health Autorities (*Agences Régionales de Santé*) have been created to be in charge of the health policy at the regional level. They should coordinate and improve prevention policy; they should control and improve the territorial distribution of health professionals and try to better articulate ambulatory care and hospital. They would also be in charge of the control of the quality of health care by collecting data on health and by improving professional practices. Brought under the authority of a new pilot of health policies to the regional level (with the image of a "prefect" of health), joining together various local administrations, the objective is to set up a true coherent policy of health at regional level, including guaranteeing equal access to health care, a better effectiveness of the expenditure or a better distribution of professionals on the territory. It took a long time to adopt this law because of the various protests by the medical profession, especially opposed to the attempt at restricting their freedom of settlement, or to the empowerment of hospital directors (who are not doctors but civil servants).

In June 2009, the main health insurance fund (CNAMTS), for its part, has proposed an important new modality of pay for GPs, with the establishment of the contract for improvement of individual practices (CAPI), adopted in late 2009 by one third of doctors concerned. The contract is supposed to promote premium payment based on performance. In this frame GPs are being rewarded with a bonus of up to EUR 7 per patient if they achieve the objectives set in an agreement in compliance with following the recommendations formulated by the High Authority for Health: Vaccination against influenza for persons of more than 65 years, screening breast cancer for women over 50 years, increased generic prescriptions and better monitoring of chronic diseases (diabetes and hypertension).

In 2010 and 2011, there has not been any important reform of the French Health care system, since the most important reform was adopted in 2009 (*loi HPST* and since the government was concentrated on the pension reform. However, since the sickness insurance funds deficit are still high (EUR 11,6 billion in 2010 and around 10 billion in 2011[45]), some financial measures have been decided in late 2010 and in late 2011 within *Loi de Financement de la Sécurité sociale*.

In 2010, it has been decided:

- a decrease of 35% to 30% reimbursement of medicines so-called "blue labels" medicines for minor illnesses and whose medical record (SMR) is considered less important;
- a decrease in the level of support for medical devices (medical equipment or other items to the exclusion of drugs: implant, prosthesis, surgical instrument ...) by 65% to 60%. A measure which does not include medical devices used for serious diseases (devices implanted in the hospital, wheelchairs ...) which will be reimbursed at 100%;
- a reassessment of the threshold fixed contribution (co-payments of EUR 18) for hospital acts more expensive than EUR 120[46].

[45] COMMISSION DES COMPTES DE LA SECURITE SOCIALE, « Les comptes de la sécurité sociale : Résultats 2010, Prévisions 2011 et 2012 » http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics//114000583/0000.pdf p. 7.

[46] http://www.gouvernement.fr/gouvernement/plfss-2011-notre-politique-d-assurance-maladie-garantit-un-acces-aux-soins-de-haut-nive.

In 2011, the main measures have again been financial, planning some decrease in drugs' price, further efficiency gains in hospitals, and some changes in sickness pay. On the resources side, the government has planned some new resources (up to EUR 1,9 billion) for the Health insurance systems coming from the reintegration of overtime in the calculation of general relief for low wages (yield of EUR 600 million); the reduction in the abatement of CSG-CRDS from 3% to 2% (yield of EUR 595 million); the increase of the "social package" for private firms from 6 to 8% (yield of EUR 410 million); the homogenisation of the base of the social contribution of corporate "Contribution sociale de solidarité" in the financial sector (yield of EUR 150 million) and the imposition of the "complément de libre choix d'activité" to the CSG (yield of EUR 140 million).

A new legislation, *Loi Fourcade*, which amends the *Loi HPST* has been passed in 2011. The main measures aims on the one hand to better provide the juridical base for *Maison de Santé* (Health centers) in order to develop medical collective practice, but also to better protect doctor's freedom (medical secret, freedom of installation, no penalties for not helping areas where doctors are lacking, no obligation to announce in advance when the doctor will be absent, etc.).

2.3.2 Debates and political discourse

Despite the fact that health insurance is counting to the highest deficit of the whole social protection system, few new reforms are announced by the main candidates to the Presidential election. François Hollande (Socialist) is promising to change the tariffication systems in hospital in order to reduce the managerialisation of public hospitals. He also wants to reduce queuing, guarantee that anybody could reach emergency care within 30 minutes, and he wants to cap the possibilities for doctors to implement extra fees (dépassement d'honoraires).

Nicolas Sarkozy has not yet really presented his ideas about the future of the French health care system.

2.3.3 Impact of EU social policies on the national level

As amply demonstrated by research, there is no explicit references to EU social policies when reforming French health care, despite some orientation of reforms that fit the OMC guidelines (see below, critical assessment)[47]. One can however signal that the government is emphasising the budgetary constraints to explain its Sickness insurance policies.

2.3.4 Impact assessment

Next to future financial problems to come, inequalities in health are still also a major problem for the French health care system. France has a very high social gradient in health. As a study published by the French institute for statistics (INSEE) in 2005 has shown, life expectancy at the age of 35 years is seven years higher for male white-collar employees (*cadre*s) than for male blue-collar workers. If this gap is lower and stable among women, it has increased among men over the last 15 years[48]. Recent research confirms these data. As explained below, these recent research identifies the organisation of the health care system and its reforms as one of the cause of inequalities in health[49].

[47] See Caune, H., Jacquot, S., Palier, B., 'Boasting hte National Model' in *The EU and the Domestic Politics of Welfare State Reforms. Europa Europae*, Jacquot, S., Graziano, P., Palier, B., Palgrave, 2012.

[48] INSEE PREMIERE, 2005, "Les differences sociales de mortalité", juin, numéro 1025.

[49] See Fassin D., Bataille P., Herbert C. et al., *Lutter contre les inégalités sociales de santé: politiques publiques et pratiques professionnelles*. Rennes: Presses de l'EHESP, 2008; Or Z., Jusot F., Yilmaz E., The European Union Working Group on Socioeconomic Inequalities in Health (2009), "Inégalités sociales de recours aux

This increase can partly be explained by the health care financial reforms. In order to ensure the financial viability of the system, all governments since the 1990s have decided to limit and diminish the re-imbursement guaranteed by compulsory health insurance, thus leaving more costs to be covered by French patients. This has given a growing importance to out-of-pocket payments, which are partly covered by the voluntary/complementary health insurances. As shown by IRDES, complementary health insurance covers 12.9% of the expenditure, and 9.1% of the costs remain to be paid by the insured. However, only 84.9% of the French population are covered by a complementary scheme, 7.4% are covered by the complementary universal sickness scheme (CMUC) and 7.7% do not have any complementary insurance[50]. The remaining ones are to be found among low income groups. As shown by the French Observatory on inequalities (*Observatoire des inégalités*), 10% of workers and employees of small companies do not have complementary health insurance (*mutuelle*) and 22% of the poorest do not have such insurance, whereas the rate is at 7.7% for the whole population. Among the persons living under the poverty rate (60% of median income) and being under the age of 50, 21% have not seen a doctor during the year before, whereas the rate is 17% for the rest of the population. 53% of the poorest did not consult a specialist, whereas it was only 40% for the rest of the population[51]. These data indicate a postponement (and sometimes even renouncing) of access to health care system in France for the poorest, despite the implementation of the universal sickness scheme (CMU). Recent studies reported also by the *Observatoire des inégalités* show moreover that a lot of doctors refuse to treat patients with CMU, mainly because they cannot overcharge them (implement a "*dépassement d'honoraire*").

The measures decided in 2010 and 2011 aimed at further increasing co-payment as well as the trend to increased *dépassement d'honoraires* can only reinforce these traits whereby the most needy have not the same access to health care than the rest of the population.

Another critical issue in the access to health care is the fact that the distribution of doctors is very uneven on the French territory, as this has also been pointed out several times by the High Council for the future of Health Insurance *(Haut Conseil sur l'Avenir de l'Assurance Maladie)*. The density of liberal specialists is 88 for 100,000 inhabitants in France, but only 34 in the *Department* Lozère and 244 in Paris[52]. This is partly due to the fact that in France, doctors can settle where they want, with no regulation. In 2006, the Government announced in the media its intention to develop a way to refuse installation where too many doctors were already settled, but doctors apprentices went on strike and the Government withdrew his proposal. Within the new law *Hôpital, patients santé et territoire*, the government was planning new forms of incentives for doctors to settle in cities and regions which are lacking of doctors. However, due to protest by the medical profession, the government has again withdrawn any coercive measure as reported above and the *Loi Fourcade* has eliminated all possibilities for government and regional agencies to put pressure on doctors.

2.3.5 Critical assessment of reforms, discussions and research carried out

As shown with the strong debate and lobbying around the law *Hôpital, patients, santé et territoires*, the main critique to be made on the recent French reforms of the health care sector is the ongoing absence of capacity of the State to regulate the sector against the will of the medical profession. When it was presented the law contained a lot of orientation fitting with the

soins en Europe: Quel rôle pour le système de soins?", *Revue Economique*, 60, 2: 521-543 and HADA, F., RICARDO, C., TOURAINE M-S., *Les inégalités face à la santé.* Paris: Fondation Jean Jaurès: 2009: 71 p.

50 IRDES, "L'Enquête Santé Protection Sociale 2006, un panel pour l'analyse des politiques de santé, la santé publique et la recherche en économie de la santé", *Questions d'économie de la santé*, numéro 131, April 2008.

51 OBSERVATOIRE DES INEGALITES, (http://www.inegalites.fr/).

52 Haut Conseil pour l'Avenir de l'Assurance Maladie, premier rapport, janvier 2004.

objectives agreed in the OMC (better distribution of doctors over the territory to improve equality of access, limiting overbilling to restrain financial discrimination, empowerment of hospital directors and creation of regional health agencies to improve the coherence and consistency of health policies, better coordination between ambulatory and hospital care, improved prevention …). However, during the long lasting discussion of this law (which started in February 2009 and finished in July 2009), the medical professions organised several strikes in hospitals, mass demonstrations and intense lobbying, so that on the 12th of May, the French President, Nicolas Sarkozy, felt obliged to announce many concessions to the medical professions (such as a weakening of the future power of the hospital directors), that all undermine the main innovation within the law.

Of special importance is the incapacity to improve equal access to health care in the French system. Inequalities in health are one of the major drawbacks of the French health care system, but it does not seem to be preoccupying so much the government since no serious attempt to overcome these have been implemented, and all the little efforts planned within the Law *Hôpital, patients santé et territoires* have been withdrawn under the pressure of the medical profession and the following *Loi Fourcade*.

As stated in the previous section, these inequalities are partly due to the increasing role of the private complementary health insurance, not accessible to all. The publicly funded scheme to compensate for the lack of a complementary health insurance (CMU see above) is not preventing discrimination and inequalities in access to health though.

Indeed, various tests and studies[53] accomplished under the authority of the *Fonds CMU* have shown that doctors who are allowed to overbill their patient (charging a fee which is higher than the standard fixed tariff reimbursed by the health insurance fund) tend to deny access to their practice to CMU holders. A test implemented by the fund in charge of the financing of the CMU has shown that 41% of the specialists and 39% of the dentists (most of them practicing overbilling), refuse to treat patients covered by the universal sickness scheme (CMUC) since they cannot overbill them[54]. Overbilling has become a major phenomena in the French health care system. A report elaborated by the General Inspectorate of Social Affairs (IGAS) in the year 2007 shows an important increase in the practice of overbilling in the past 10 years and has shown that out of around EUR 18 billion of fees paid to doctors in the ambulatory sector, more than EUR 2 billion are due to the practice of overbilling[55]. Here again, the government planned to try to limit overbilling by creating a formal and better controlled sector were overbilling would be accepted but regulated. Under the pressure of the medical profession, all regulation has been postponed until 2013.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

French public provision for the long-term care needs of the dependent elderly and the disabled relies on a two-pronged system. On the one hand, the health insurance scheme covers the cost of health care provided in an institutional setting to the dependent elderly or to disabled patients. It also finances long-term care units in hospitals, as well as nursing care provided in the patient's home. Such health care costs are paid for directly by the health insurance scheme, i.e. patients do not need to advance the money themselves.

[53] Fonds CMU, DIES, 2006, "Analyse des attitudes de médecins et de dentistes à l'égard des patients bénéficiant de la Couverture Maladie Universelle complémentaire".

[54] Fonds CMU, DIES, 2006, "Analyse des attitudes de médecins et de dentistes à l'égard des patients bénéficiant de la Couverture Maladie Universelle complémentaire".

[55] IGAS, 2007, "Les dépassements d'honoraires médicaux"rapport, avril.

On the other hand, two schemes, essentially financed by the State and by local authorities, provide social benefits to the dependent elderly and to the disabled to help them meet some of the cost of care that is not covered by health insurance, whether that care is provided in institutions or in a domiciliary setting.

For the disabled, a new benefit came into force in January 2006, called the *Prestation de Compensation du Handicap – PCH –* (Disability compensation benefit) which aims to better cover the needs of the disabled whatever the causes of the disability and the age or life-style of the person. This benefit is intended to help cover the needs of the disabled person regardless of whether those needs have to do with professional insertion, home adaptation, human and technical aids, etc. This benefit replaces the previous ACTP (third person compensatory benefit) although those who already received the ACTP can continue to remain under that scheme if they so wish.

End of June 2009, 71.700 people were receiving the PCH, compared to 43,000 in 2008, which represents a 67% increase over a year. This sharp increase can be attributed both to the fact that some people who previously were covered under the ACTP scheme transferred to the PCH benefit, as well as to the fact that this new benefit is open to a larger category of people than the former ACTP scheme (the ACTP was only open to people over the age of 20, whereas the PCH can also be claimed by children regardless of age). Average spending per beneficiary is EUR 980 per month (DREES, 2009[56]).

The dependent elderly can receive the Allocation Personnalisée d'Autonomie – APA (Personalised Autonomy Benefit) which is a universal benefit for people over 60 that came into force in 2002. This benefit is calculated based on a "help plan" designed for each individual, on the basis of the assessment of the person's needs. The APA benefit is intended to cover part of the cost of the "help plan", the rest (about one quarter of the total amount on average) is paid by the beneficiary through user fees which increase proportionally to the elderly's income. Elderly people with an income below EUR 689.50 per month do not pay user fees. The benefit amount thus varies both according to the person's level of dependency (established by a socio-medical team, using a nation-wide unified grid – the AGGIR grid – which identifies 6 levels of dependency, with only the first 4 levels being taken into account for the granting of the APA benefit) and according to the elderly's financial resources.

At the end of June 2009 there were 1,117,000 recipients of the APA benefit. 61% of APA beneficiaries lived at home, and 39% in special accommodation for the elderly. The average amount of the help plan granted to people receiving domiciliary care was EUR 494 per month, of which about a quarter (EUR 120 on average) was covered by user-fees. The amount of the help plan varies according to the level of dependency from EUR 348 to EUR 1,009 per month (DREES, 2009[57]).

The fast increase (partly unforeseen) in the number of APA recipients since it came into force in 2002 (when there were only 469,000 beneficiaries) has put a strain on public finances, especially for the départements who finance over two thirds (72%) of the cost of the APA, the rest being covered by the National Solidarity Fund for Autonomy – CNSA. Today, altogether EUR 22 billion are spent on long-term care.

For many years now, a number of issues have been highlighted by professionals, by the CNSA, in the public debate, and by the government. These issues relate to the costs born by the dependent elderly and their relatives, especially for institutional care, to the lack of

[56] DREES, "L'allocation personnalisée d'autonomie et la prestation de compensation du handicap au 30 juin 2009", Etudes et Résultats, n°710, novembre 2009.

[57] Ibid.

coordination between the different actors in charge of long-term care which makes access to services particularly difficult for the dependent elderly and very geographically unequal, to the insufficient provision of institutional care and to the quality of domiciliary care.

To address these issues, the government had announced in 2007 that long-term care would be one of the priorities under its five year term in power, and that a reform would be undertaken to better cover the needs of the dependent elderly.

2.4.2 Debates and political discourse

The President had announced at the end of 2007 that a bill would be proposed to the Parliament early 2008 concerning the creation of a fifth social insurance branch, aiming at covering the loss of autonomy for the disabled and the elderly. A senatorial information mission was set up in order to follow up on the preparatory work around this proposed scheme. The senatorial mission published its report in July 2008 (the 2008 Vasselle Report[58]). However, the adoption of the bill relative to this fifth social insurance scheme ("l'assurance cinquième risque") has been postponed several times, first to October 2009, then to the first half of 2010, then to autumn 2011, by which point the idea of a fifth social insurance branch had been more or less abandoned following some new reports (the Rosso-Debord 2010 report[59] - cf. Annual National Report 2011 – and the Vasselle 2011 report[60]).

The 2011 Vasselle report to the Senate sought to assess the progress made since the 2008 Vasselle report (cf. Annual National Report 2010), and to revise the positions that it had put forward in the 2008 report, the position of the government having since changed on the issue of the creation of a fifth social insurance branch, not least due to uncertain demographic forecasts making the cost of such a scheme difficult to predict, and to financial constraints linked to the economic crisis and the bad state of public finances.

Among the guidelines adopted by the Senate based on this report are:

- The rejection of the proposal to create a fifth branch of social security given the worsening situation of public finances,
- The principle of a "mixed public-private financing", combining a "high base level of solidarity" with (non-compulsory) private insurance involved in a complementary manner,
- Widespread coverage of the population by private insurance through the reorientation of life insurance policies or retirement plans towards a dependence guarantee, along with the integration of a dependence guarantee in the supplementary health coverage contracts,
- The possibility to reclaim part of the dependency benefit on the inheritance of the more wealthy elderly to finance part of the personal autonomy allowance (APA)
- The introduction of a second day of solidarity,
- The alignment of the General Social Contribution (CSG – Contribution Sociale Généralisée) rate paid by retirees on that of working people.

There is thus a clear re-orientation of the debate away from the idea of setting up a fifth social insurance scheme, the government having highlighted the difficulty in financing a new social insurance scheme in the present context of important public deficits.

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[58] Cf. Annual Report 2010 France.

[59] Rosso-Debord, Valérie (2010), Rapport d'information déposé par la commission des affaires sociales en conclusion des travaux de la mission sur la prise en charge des personnes âgées dépendantes, Assemblée nationale, n°2647, 23 juin 2010.

[60] Vasselle, Alain (2011), Rapport d'information fait au nom de la mission commune d'information sur la prise en charge de la dépendance et la création du cinquième risque, Sénat, n°263, 26 janvier 2011.

Some of these proposals were immediately discarded by the Minister of Solidarity and Social Cohesion, Mme Bachelot-Narquin. Indeed she noted that the setting up of a compulsory private insurance was no longer viewed as an alternative. The consultations had shown that none of the actors involved were really in favour of such an option. The idea of reclaiming some of the APA benefit on the inheritance of those people with higher assets has also being progressively abandoned, as well as the idea of introducing a second "day of solidarity" contribution which only applies to salaried workers. The proposal to restrict the benefit to the most dependent only (i.e. excluding those people classified in level 4 of the AGGIR-grid) has also being rejected. The idea to raise the General Social Contribution (CSG) by 0.1% (which would bring in an extra EUR 1.3 billion) did not meet the President's approval either as he does not want to take up the idea of aligning the general social contribution rate of retired people on that of working people as that would possibly alienate its elderly electorate.

Further to these two reports, a national debate was launched in February 2011, involving a six months consultation process with parties, trade unions, associations, representatives from religious groups, etc. Four task groups were set up to deal with different aspects of long-term care. The first group addressed the issue of ageing and the place of elderly people in society. The second group dealt with the demographic and financial forecasts of long-term care. The third group dealt with care facilities and support for the elderly, addressing amongst other things the use of the new care technologies and examining the transformation of professions in the care sector. Finally, the fourth group sought to develop a strategy for the long-term care coverage of the dependent elderly. The issue of financing (new modes of financing and the cost for individuals and families) was at the centre of this group's reflexions. These consultations provided the basis of a report submitted to the President in July 2011[61]. This was intended to lay the ground for the proposal of some preliminary measures to be integrated in the Social Security Funding Bill in 2012 (voted in the autumn of 2011).

However, no financial measures were integrated in the Social Security Funding Bill and the government announced that any new measure would be postponed to early 2012. Beginning of January 2012 the government announced that reform plans had been dropped. According to the government, it would be irresponsible to set up new measures given the economic crisis and dire state of public finances[62].

2.4.3 Impact of EU social policies on the national level

There has not been any debate on the OMC in the field of long-term care. The EU 2020 strategy does not seem to have had any impact on the debates around long-term care reform in France either. In fact, the French National Reform Programme 2011 only mentioned long-term care in a small box, and in very general terms.

Where the EU has had an impact is in the framing of the need to reform the financing mechanisms of long-term care as a means to comply with the country's European engagement to reduce its public debt and deficit levels, in a context of financial crisis, thus making it necessary to find new ways of financing long-term care, without aggravating the State's financial situation. As a result, the government has renounced introducing any new financial measures.

[61] RAHOLA, Axel, Rapporteur du Comité interministériel de la dépendance (2011), *Synthèse du débat national sur la dépendance*, Ministère des Solidarités et de la Cohésion sociale.

[62] Le Monde (05-09-2011), « Le discret enterrement de la réforme de la dépendance ».
Le Monde (06-01-2012), « Roselyne Bachelot renonce à la réforme de la dépendance ».

2.4.4 Impact assessment

Amongst the main issues that have been at the forefront of public debate, the issue of the costs that users have to meet themselves for the care they receive, especially in institutions, has been particularly central. Much of the present reform work aims at addressing this issue, but since no reform has been implemented so far, the situation has not changed in this respect.

Another issue that has come to the fore is that of the quality of the care provided, both in institutional and in domiciliary settings, and how random the quality of care can be, irrespective of the level of user-fees. One problem here is that there is no coherent mode of quality control, not least in the field of non-medical domiciliary care.

This is in large part due to the fact that no unified legislation on domiciliary care services exists. These services can be set up under two different types of legislation, and the quality requirements imposed are further laid down in a variety of texts and procedures. Domiciliary care companies themselves sometimes set up their own certification procedures and labels and all these rules and regulations are simply piled up on each other without bringing any added value and remain purely procedural, not least as quality controls are only carried out in the form of desk audits and never based on interviews with the recipients.

This problem is further accentuated by the implication of numerous state services in this field without any real coordination between them. Finally, quality control is rendered difficult by the fact that domiciliary care is often provided through private (person to person) contracts. This is paradoxically the case for the most dependant elderly in need of a large number of care hours, who, although they would benefit more than others from relying on an operational provider to coordinate their service needs, often resort to direct employment (private person to person contracts) as a less costly option.

2.4.5 Critical assessment of reforms, discussions and research carried out

Amongst the main issues that have been at the forefront of public debate, the issue of the costs that users have to meet themselves for the care they receive, especially in institutions, has been particularly central. Since no reform has been implemented, the situation has not changed in this respect.

Another critical issue relates to the governance of the system. As the system stands today, there are a great number of actors involved in the financing and organisation of long-term care which makes the system very difficult to understand and to make good use of for the dependent elderly and their relatives, and also creates many inequalities between beneficiaries.

Finally, the issue of quality control still needs to be addressed.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

France's employment rate of workers aged 55-64 has been below the EU-27 and EU-15 average for a long time. However, in recent years, the government has introduced a series of measures to increase the labour market participation of the elderly:

1) Over the last few years, most public early retirement schemes have been phased out and no public early retirement schemes have been reintroduced during the crisis. The only exception is the newly introduced possibility to terminate job contracts by a mutual agreement between the employer and the employee (*rupture conventionnelle du contrat de travail*). This new

regulation, which was introduced in 2008[63], gives workers the possibility to draw unemployment benefits as if they had been unilaterally fired by their employer. Older workers have been the most likely to use this possibility, as it allows them to draw unemployment benefits just before retiring[64].

2) The 2009 bill on the financing of social security (*Loi de financement de la Sécurité Sociale - LFSS - pour 2009*)[65] included a number of measures aiming at promoting longer working lives: a) increase in the pension bonus rate – *surcote* – to 5% p.a.; b) lifting of restrictions to the accumulation of remunerated employment with pension for pensioners aged 65 or more as well as for pensioners aged 60 or more who draw a full pension; c) increase to 70 years (previously 65 years) in the age at which private-sector companies can send a worker to retirement without having to ask for his or her consent; d) in order to force companies to negotiate on older workers' employment, introduction of a 1% penalty contribution on the wage bills of companies that will not have reached an agreement by 2010. The 2010 bill on the financing of social security (*Loi de financement de la Sécurité Sociale - LFSS - pour 2010*)[66] confirmed the last measure and introduced the 1% penalty contribution for all companies employing more than 50 workers that did not reach an agreement by 31 December 2010.

3) Following reforms enacted in 2010 and 2011, the minimum retirement age in the *régime général* and in most statutory pension schemes is to increase to 62 years by 2017. For each cohort born between 1951 and 1955, the minimum retirement age is increased by 5 months every year.

Date of birth	**Minimum retirement age**	**Earliest possible date of retirement**
July 1st 1951 to December 31st 1951	60 years and 4 months	November 1st 2011
1952	60 years and 9 months	October 1st 2012
1953	61 years and 2 months	March 1st 2014
1954	61 years and 7 months	August 1st 2015
1955	62 years	January 1st 2017

Source: http://vosdroits.service-public.fr/F14043.xhtml.

Nevertheless, the possibility of retiring before the minimum statutory retirement age is maintained for two categories of workers:

a) workers with long careers, i.e. those who started working between the age of 14 to 17 and who have a long contribution record (42.5 years), have the possibility to retire from age 56 and draw a full pension from the *régime général*. However, the 2010 reform has tightened eligibility for these schemes;

b) workers who have a permanent incapacity to work of at least 20% or an invalidity of a comparable level.

63 http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000019066178

64 CENTRE D'ANALYSE STRATEGIQUE, « La rupture conventionnelle du contrat de travail », Note d'analyse 198, October 2010.

65 http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000019942966.

66 http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000021528998

2.5.2 Participation in society

There is no specific status for voluntary or unpaid work (*bénévoles*). Such periods are not taken into account for eligibility for social security benefits. However, like all French residents, bénévoles are covered by the *couverture maladie universelle* (universal sickness coverage). Moreover, some "bénévoles" may qualify for other benefits if their status is combined with a work contract[67]. There do not seem to be any political debates about the social security status of voluntary workers.

2.5.3 Healthy and autonomous living

As part of the European Year of Active Ageing and Intergenerational Solidarity in 2012, the Ministry of Solidarity and Social Cohesion and the Ministry of Labour, Employment and Health organised a launching conference on February 28th 2012. There have not been any reports in the media regarding this conference, nor has the Ministry of Solidarity published anything yet regarding the discussions held or the initiatives put forward. Since this conference was launched shortly after the government announced that no new measures would be taken in the field of long-term care, the government will probably want to keep a low profile on these issues also.

[67] HERITIER Luc « La protection sociale des bénévoles et des volontaires : Présentation des dispositions", Revue française des affaires sociales, 2002/4 http://www.cairn.info/revue-francaise-des-affaires-sociales-2002-4-page-83.htm.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R2; R5] AMAR Elise, "Participation, intéressement et épargne salariale en 2009: un recul des montants distribués", *Dares – Analyses*, nr 63, August 2011, 9 p. http://www.travail-emploi-sante.gouv.fr/IMG/pdf/2011-063-2.pdf.

"Participation, intéressement and épargne salariale in 2009: sums distributed through these schemes have decreased"

This paper shows developments of profit-sharing schemes (participation), bonuses linked to company performance (intéressement) and salary saving schemes (épargne salariale). This is important, because the PERCO (plan d'épargne retraite collectif), one of the retirement savings plans created by the 2003 Fillon Law, is tightly linked to these schemes. The paper shows that 57.2% of workers in the private sector, except in agriculture, were covered by at least one of these schemes in 2009. 88% of people covered work in companies employing more than 50 workers and coverage is highest in large companies. Coverage and the sums distributed are highest among cadres. The sums distributed in these schemes have decreased by 10% between 2008 and 2009, with the exception of the PERCO which has continued to grow. The total sum of employers' matching contributions in the PERCO has increased by 7%.

[R5] ANDRIEUX Virginie, AUBERT Patrick, BARTHELEMY Nadine, CHANTEL Cécile, HOUSSET Félix, LABORDE Charline, LEQUIEN Laurent "Les retraités et les retraites en 2010", Etudes et Résultats, Drees, n° 790, February 2012. http://www.sante.gouv.fr/IMG/pdf/er790.pdf

"Pensioners and pensions in 2009"

Based on statistical data, this paper gives an overall picture of the situation of French pensioners in 2010. France counts approximately 15 million pensioners. Since 2004, the number of pensioners increases by 350,000. However, this increase has slowed down in 2009, because of tighter eligibility criteria for early retirement due to a long career. The average pension is EUR 1,216 a month, i.e. 1.9% higher than in 2009. Half of this increase is due to statutory indexation of benefits. However, the other half of this increase is attributable to the death of older and poorer pensioners and their replacement by younger pensioners with better contribution records.

[R1; R5] BLANCHET Didier, BUFFETEAU Sophie, CRENNER Emmanuelle, LE MINEZ Sylvie, « Le modèle de microsimulation Destinie 2: principales caractéristiques et premiers

résultats », Economie et Statistique, Economie et Statistique, nr 441-442, October 2011, 21 p. http://www.insee.fr/fr/ffc/docs_ffc/ES441F.pdf

"The Destinie 2 microsimulation model: main features and first results"

The Destinie model is a microsimulation model that has been developed and used and the INSEE since the mid-1990s and which is mainly used for old-age pensions. A new version of this model has been developed since 2005. This article presents its main features. The objective of the updating of the model has been to introduce a more flexible tool. The new version consists of two separate blocks. The first block produces demographic and career biographies whose coherence with demographic and employment projections has been reinforced. The second block simulates pension rights on the basis of the biographies produced by the first block. The article presents examples of simulations. One of the advantages of the model is that it allows to calculate rights at the household level. The model shows for example that the living standards of pensioners should reach around 70% and 75% of that of active workers.

[R1; R5] BLANPAIN Nathalie, "L'espérance de vie s'accroît, les inégalités sociales face à la mort demeurent", Insee Première, nr 1372, October 2011, 4 p. http://www.insee.fr/fr/ffc/ipweb/ip1372/ip1372.pdf

"Life expectancy increases, social inequalities regarding death persist"

This study is based on the "Echantillon Démographique Permanent" sample of the INSEE (French National Institute of Statistics). It shows that inequalities regarding life expectancy have been persistent and have remained equally strong over the last 25 years. Male white-collar employees live on average 6.3 years longer than male blue-collar workers. Among women, the difference between the life expectancies of the two categories is 3 years. Whatever their social category, women live longer than men. Even female blue-collar workers live longer – on average by 1.5 year – than male white-collar workers. Differences in mortality between white-collar and blue-collar workers decrease with age.

[R1; R5] BURRICAND Carine, DUC Cindy, LERMECHIN Hugues "Présentation et applications de l'outil Caliper (Calcul interrégimes des pensions de retraite) : document de travail", Drees - Série Etudes et recherches, nr 111, November 2011, 90 p. http://www.sante.gouv.fr/IMG/pdf/serieetud111-2.pdf

"Main features and uses of the Caliper (Calculation of inter-scheme pension rights) model: working paper"

The Caliper model is used to simulate pensions according to the scenarios chosen by the legislator and therefore allows analysing the consequences of reforms by comparing pension rights at the individual level in the different legislative solutions under consideration. Its advantage is that it also allows taking into account the situation of "polypensionnés" (i.e. pensioners drawing their pension from several statutory pension schemes). The model integrates legislation from the two dozens of regimes that co-exist in France. To provide an example of its possible uses, the paper analyses the cumulative impact on pensions of the increase in the number of years taken into account for the reference wage.

[R2; R5] CONSEIL D'ORIENTATION DES RETRAITES (COR), « Retraites: la situation des polypensionnés - Neuvième rapport ». Paris: COR, September 2011, 224 p. http://www.cor-retraites.fr/article403.html

"Pensions: the situation of pensioners drawing their pension from several statutory schemes – Nineteenth report"

This report has been commissioned by the Ministry of Social Affairs, as a result of the 2010 reform bill. The report is divided into two parts: the first part describes who the

"polypensionnés" (i.e. pensioners drawing their pension from several statutory schemes) are. The second part studies the implications of this status for the level of retirement benefits. According to the report, about 40% of men and 30% of women among current pensioners are "polypensionnés". The number of polypensionnés has decreased between the generations born in the 1920s and those born in the 1960s, due to the decline of the agricultural sector. However, for the generations born in the 1960s, it would seem that their number would be on the rise, but the report says it is not possible to extrapolate if this trend will continue in the future. Among current pensioners, polypensionnés have on average had longer contribution records and have therefore a higher pension than people drawing their pension from one statutory scheme. The report shows that, due to the fact that their pension is calculated according to different types of benefit formulas, being a polypensionné can sometimes be an advantage and sometimes a disadvantage with regard to benefit levels.

[R1; R2] CONSEIL D'ORIENTATION DES RETRAITES (COR), « Retraites: la rénovation des mécanismes de compensation - Dixième rapport ». Paris: COR, October 2011, 125 p. http://www.cor-retraites.fr/IMG/pdf/doc-1583.pdf

"Pensions: renovating compensation mechanisms – Tenth report"

This report has been commissioned by the Ministry of Social Affairs, as a result of the 2010 reform bill. The first part of the report presents the history and the functioning of compensation mechanisms between different statutory schemes. The second part presents the issues raised by these compensation mechanisms: are they still justified? Do current parameters meet the initial aims of compensation? Should compensation be extended to other domains (derived rights and supplementary pension schemes)? After having presented a number of fairness criteria, the third part suggests two possible pathways for the evolution of the system. In continuity with existing mechanisms, the first one would consist in preserving compensation based a flat-rate reference benefit. The second pathway would consist in creating a reference benefit that would be proportional to workers' duration of insurance and the wages earned during their career. The report presents simulations for both pathways.

[R5] EL MEKKAOUI DE FREITAS Najat, DUC Cindy, BRIARD Karine, MAGE Sabine, LEGENDRE Bérangère, "Aléas de carrière et pensions de retraite", Economie et Statistique, nr 441-442, October 2011, 14 p. http://www.insee.fr/fr/ffc/docs_ffc/ES441H.pdf

"Career interruptions and old-age pensions"

This article studies the consequences for the level of pensions of periods of unemployment, part-time work and inactivity for typical cases of individuals born in 1938, 1943 and 1948. The study uses data from the *Patrimoine* survey of the INSEE (French National Institute of Statistics). The study shows that the impact of such periods is reduced for all earnings profiles due to the existence of non-contributory benefits. The size of these impacts is nevertheless different for pensions drawn from statutory schemes and from supplementary schemes. Overall, pension rights given for periods of childrearing significantly limit the effect of periods of inactivity on pensions. On the contrary, periods of part-time work can lead to a significant drop in the level of pensions due to unaccrued rights in supplementary schemes, especially for « cadres » (i.e. managers, engineers and foremen). The effect of unemployment is more important when it happens in periods of high earnings, i.e. generally at the end of workers' careers.

[R4] MINNI Claude, "Emploi et chômage des 55-64 ans en 2010", Dares – Analyses, nr 75, September 2011, 12 p. http://www.travail-emploi-sante.gouv.fr/IMG/pdf/2011-075.pdf

"Employment and unemployment of workers aged 55-64 in 2010"

This paper presents an analysis of data from the Enquête Emploi, the INSEE's labour market survey. In 2010, 42.5% of workers aged 55-64 are active in France. 39.7% are employed and 2.8% are unemployed. When one controls for the effect of demographic structure, survey data show that the participation of older workers in the labour market has increased continuously since 2001, and this for all ages, for men and for women. With the phasing out of most public early retirement schemes, this increase has been more rapid since 2008. Compared with EU-15 countries, the employment rate of workers aged 60-64 is still very low in France (17.9% compared to 32.5 in 2010).

[H] Health

[H1] Cornilleau Gérard, Debrand Thierry, "Crise et déficit de l'assurance maladie. Faut-il changer le paradigme ?", In : Les finances publiques dans la crise, *Revue de l'OFCE*, n°116, 2011/01, pp.315-332.

"*Crisis And Health Insurance Deficit, Should One Change The Paradigm?*"

Part of the deficit of health insurance, about 1 percent of GDP, is mainly resulting from the economic crisis which has reduced revenues from payroll taxes and CSG. This deficit contributes to the automatic stabilisation of the economy and it should have disappeared with the return of growth. As it is not returned, the voluntary reduction of the deficit or lower spending would be counter-cyclical and must be rejected. But part of the deficit, which can evaluate between 0.35 and 0.7 GDP points, results from the existence of a gap between the structural growth of health spending and that of GDP. For a good long-term management of health insurance, it is necessary to eliminate the structural deficit, estimated between 1.4 and 2.8 percentage points of GDP if nothing is done in 2020. Until now, it has been contained by an increase in taxes to finance health insurance and a lower reimbursement rate. Seeking a better control of expenses by a change in the organisation of the care system (collective exercise of medicine promoting complementarity and substitution between professions; build a better system that integrates the ambulatory and hospital, ...) and a reform of modes of financing (reduction of the role of fee-for-service) to reduce inequalities in access to care (in especially those related to excess fees) deserve to be discussed in the context of discussions on the evolution of health expenditure and financing.

[H3] Després, Caroline, Dourgnon, Paul, Fantin, Romain, Jusot, Florence, "Le renoncement aux soins pour raisons financières : une approche économétrique » *Questions d'économie de la santé* n° 170. 2011/11, IRDES, http://www.irdes.fr/Publications/2011/Qes170.pdf

"Renouncing to health care for financial reasons, an econometric approach"

France, although provided with a system of social protection with universal coverage, knows social inequalities in access and utilisation of health services. The analysis of the determinants of renouncing to care for financial reasons sheds new light on this question. In 2008, 15.4% of the adult population claims to have given up medical care for financial reasons during the last twelve months. Financial barriers are concentrated on dental care (10% of the population) and to a lesser extent, the optical (4.1%) and consultations with GPs and specialists (3.4%). These difficulties in access to care are partly explained by the limits of the social protection system. The absence of additional coverage is an important factor. Nevertheless, this study reveals other factors related to the personal life history, particularly the social past, present and future prospects. This study also shows that fees charged by health professionals who can set their own fees are crucial for shaping accessibility of care.

[H4] DELAS, Aurélien, "L'hôpital public, un nouvel acteur territorial entre aménagement sanitaire et rivalités stratégiques" Hérodote, 2011/4 (n° 143), pp.89-119

"Public hospitals, a new territorial *player between sanitary planning and strategic rivalries"*

Under the influence of new financing modes, French public hospitals gradually integrated the need of a territorial approach of their provision of care as well as new challenges regarding the demography of health professionals and the increasing sanitary socio-spatial inequalities. Now, public hospitals must to develop a territorial strategy of development according to their local geopolitical context which includes socio-sanitary information of the population, strengths and weaknesses of each hospital, the position of other health institutions, local medical demography and the relationships with State and local authorities. As a key player in the sanitary and economic development of a territory, public hospitals can only guarantee its durability, compete with the private sector and hope to keep its internal dynamics by building a smart territorial strategy. It includes developing cooperation ties with the other health players and increasing its hospitalisation activities and planned interventions.

[H7] Behaghel Luc, Blanchet Didier, Debrand Thierry, Roger Muriel, "Disability and social security reforms: The French case." NBER Working Paper n° 17055. Cambridge: NBER, 2011/05, 33 p.

The French pattern of early transitions out of employment is basically explained by the low age at "normal" retirement and by the importance of transitions through unemployment insurance and early-retirement schemes before access to normal retirement. These routes have exempted French workers from massively relying on disability motives for early exits, contrarily to the situation that prevails in some other countries where normal ages are high, unemployment benefits low and early-retirement schemes almost non-existent. Yet the role of disability remains interesting to examine in the French case, at least for prospective reasons in a context of decreasing generosity of other programs.

The study of the past reforms of the pension system underlines that disability routes have often acted as a substitute to other retirement routes. Changes in the claiming of invalidity benefits seem to match changes in pension schemes or controls more than changes in such health indicators as the mortality rates. However, our results suggest that increases in average health levels over the past two decades have come along with increased disparities. In that context, less generous pensions may induce an increase in the claiming of invalidity benefits partly because of substitution effects, but also because the share of people with poor health increases.

[L] Long-term care

[L] VASSELLE, ALAIN (2011), Rapport d'information fait au nom de la mission commune d'information sur la prise en charge de la dépendance et la création du cinquième risque, Sénat, n°263, 26 janvier 2011.

"Information report presented to the Senate carried out in the name of the common information mission on long-term care and the creation of the fifth social insurance branch"

This report to the Senate aims at contributing to the debate on the future financing of long-term care. It also seeks to assess the progress made since the 2008 Vasselle report, and to revise the positions that it had put forward in the 2008 report, the position of the government having since changed on the issue of the creation of a fifth social insurance branch.

[L] RAHOLA, Axel, Rapporteur du Comité interministériel de la dépendance (2011), *Synthèse du débat national sur la dépendance,* Ministère des Solidarités et de la Cohésion sociale.

"A synthesis on the national debate on dependency"

This report summarises the results of the consultations carried out by the four task groups that were set up in early 2011 as part of the national debate on the issue of loss of autonomy promoted by the Ministry of Solidarities and Social cohesion. The first group addressed the issue of ageing and the place of elderly people in society. The second group dealt with the demographic and financial forecasts of long-term care, and showed that the increasing public costs of long-term care would be limited until 2025 and moderate from 2025 to 2060. This means that no immediate measures need to be taken (from the public finances' perspective) but that public authorities need to be aware of these trends for the calibration of any new measures, in order for the public authorities to be able to control costs in the future too. The third group dealt with care facilities and support for the elderly, addressing amongst other things the use of the new care technologies and examining the transformation of professions in the care sector. Finally, the fourth group sought to develop a strategy for the long-term care coverage of the dependent elderly.

4 List of Important Institutions

Caisse Nationale d'Assurance Maladie des Travailleurs Salariés – National Health Insurance Fund for the Salaried Workers

Address: 50 avenue du Professeur André Lemierre, 75986 Paris Cedex 20
Webpage: http://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/

The National Health Insurance Fund for the Salaried Workers is the main Health insurance funds, providing health care coverage to 80% of the French population. CNMATS has one research unit, in charge of statistics and research. It regularly publishes "Points de repères" which gather statistical data on health in France, and a journal: "Pratiques et organisation des soins".

Caisse Nationale d'Assurance Vieillesse (CNAV)

Address: 110 avenue de Flandre, 75951 Paris cedex 19
Webpage: http://www.cnav.fr

CNAV is the social protection administration that manages private-sector wage-earners pension scheme. CNAV has different research units. One unit compiles and analyses statistical data. Another unit specialises in research over ageing. Main publications include: "Retraite et Société", "Cadr@ge", "Les Cahiers de la CNAV".

Caisse Nationale de Solidarité pour l'Autonomie (CNSA) – National Solidarity Fund for Autonomy

Address: 66 avenue du Maine, 75682 Paris cedex 14
Phone: 33 (0)1 53 91 28 00
Webpage: http://www.cnsa.fr/

The CNSA is a public agency that was set up in 2005. It is both a "fund" in charge of distributing financial resources, and an "agency" providing technical expertise. Its mission is to finance the social benefits geared towards the dependent elderly and the disabled; to guarantee equal treatment across the country and for all types of disabilities; and to provide technical expertise, information and guidance in order to survey the quality of services.
Main recurring publications:
The Annual Report (le Rapport Annuel): This report presents all the actions that have been carried out during the year and takes stocks of what has been achieved since the creation of the CNSA. It also addresses future orientations.
The Letter (La Lettre): The Letter is published on a quarterly basis and provides information on ongoing activities and projects, publishes interviews of people involved in the field, etc.

Commission des comptes de la Sécurité sociale – Commission on Social Security Accounts.

Webpage: http://www.securite-sociale.fr/chiffres/ccss/ccss.htm

This institution is not an administration with specific staff working for it, and has therefore no specific mail address. Created in 1979, the Commission social security accounts has the role of analysing the accounts of the social security funds. It also looks at the accounts of the complementary pensions. The Commission is chaired by the minister in charge of the social security. It meets at least twice a year, on the initiative of its president: the first meeting is held between on April 15th and on June 15th and a first estimate of the accounts of the general scheme of social security is published; the second meeting proceeds between on September 15th and on October 15th. The accounts of the whole of the mandatory schemes of social security are presented and analysed by the commission. Since the adoption of the financing law of social security, the second meeting is held around on September 20th. It is devoted to the

examination of the accounts which are used as framework for the financing law of social security.

Cour des Comptes – Financial Auditing Court

Address: 13 rue Cambon, 75001 Paris
Webpage: http://www.ccomptes.fr/fr/CC/Accueil.html

The missions of the Cour des comptes are defined by the Constitution in paragraph 1 of article 47-2: "The Cour des comptes shall assist Parliament in monitoring Government action. It shall assist Parliament and the Government in monitoring the implementation of Finances Acts and of Social Security Financing Acts as well as in assessing public policies. By means of its public reports, it shall contribute to informing citizens. […]" As an administrative jurisdiction, the Cour des comptes fulfils these missions in full independence. The Cour monitors that Ministers respect the budget appropriations voted by both assemblies. It checks results in terms of expenditures as well as receipts. It contributes to the accurate awareness of the State's financial situation. It proceeds in a similar way for the whole social security system that complies with organisational rules and budgetary principles that are far different from those of the State". Every year, the Cour releases a report on the implementation of the Social security financing Act.

Direction de la recherche, des études, de l'évaluation et des statistiques (DREES)

Address: Mission publications et diffusion, 14 avenue Duquesne, 75350 Paris 07 SP
Phone: 0033.1.40.56.80.54
Email: drees-infos@sant.gouv.fr
Webpage: http://www.sante-sports.gouv.fr/etudes-recherches-statistiques/etudes-recherches-statistiques-sante/direction-recherche-etudes-evaluation-statistiques-2-.html

DREES is the research unit of the Ministry of Health, but it publishes reports on social protection issues in general. Main publications include: "Études et resultats", "Revue française des affaires sociales", "Dossiers Solidarité et Santé" and working papers.

Haute Autorité de Santé – French National Authority for Health

Address: 2, avenue du Stade de France, 93218 Saint-Denis La Plaine Cedex
Phone: 00 33 1 55 93 70 00
Webpage: http://www.has-sante.fr/

The Haute Autorité de Santé (HAS) – or French National Authority for Health – was set up by the French Government in August 2004 in order to bring together under a single roof a number of activities designed to improve the quality of patient care and to guarantee equity within the health care system. HAS activities are diverse. They range from assessment of drugs, medical devices, and procedures to publication of guidelines to accreditation of health care organisations and certification of doctors. All are based on rigorously acquired scientific expertise. Training in quality issues and information provision are also key components of its work programme. HAS publishes various reports.

Haut Conseil sur l'Avenir de l'Assurance Maladie – High Council for the future of Health insurance

Address: Ministère de la santé, de la jeunesse, des sports et de la vie associative, 18 place des Cinq Martyrs du Lycée Buffon, 75696 Paris Cedex 14
Webpage: http://www.sante.gouv.fr/htm/dossiers/hcaam/sommaire.htm

The High council, chaired by Bertrand Fragonard, brings together 58 members representing the unions and employers, the Parliament, the State, the health insurance funds, the mutual insurance companies, the professions and health care institutions, the users, as well as qualified personalities. The High council for the future of the health insurance has four missions: to assess the system of health insurance and its evolutions; to describe the financial situation and the prospects for the health insurance and to appreciate the requirements to ensure their viability in the long-term; to take care of the cohesion of the system of health insurance regarding the equal access to care of high-quality and a just and equitable financing, to formulate, if necessary, the recommendations or reform proposals likely to answer the objectives of financial solidity and social cohesion. HACCM publishes an annual report and specific positions (avis).

Institut de Recherches Economiques et Sociales (IRES) – Institute of Economic and Social Research

Address: 16 Boulevard du Mont d'Est, 93192 Noisy-le-Grand cedex
Phone: 0033 1 48 15 18 90
Webpage: http://www.ires.fr/

IRES is a research institute whose aim is to provide studies on social and economic issues for trade unions. On the one hand, it prepares studies agreed upon by all trade unions. Its scientific programme is defined every four years. On the other hand, it prepares studies commissioned by individual trade unions. The institute employs approximately 30 researchers. Main publications include: "La Revue de l'IRES", "La Chronique Internationale de l'IRES", "La lettre de l'IRES" and working papers.

Institut de recherche et documentation en économie de la santé (IRDES) – Institute for Research and Information in Health Economics

Address: 10 rue Vauvenargues, 75018 Paris
Phone: 00 33 1 53 93 43 00
Webpage: http://www.irdes.fr/

IRDES's primary mission is to provide high quality research and information for those who are interested in the future of health care systems. IRDES's multidisciplinary team monitors and analyses trends in the behaviour of consumers and health care professionals from a medical, economic, geographic and sociological perspective. In addition, IRDES provides access to health information for general public through its documentation center.
IRDES develops and conducts periodic and targeted surveys on populations, health care professionals, and institutions, to collect data on medical care production and consumption. Partnership agreements also enable it to make use of surveys conducted by other organisations (National Institute of Statistics and Economic Studies, sickness funds, IMS France.) IRDES publishes various working papers.

Ministère du Travail, des Relations sociales, de la Famille, de la Solidarité et de la Ville – Ministry of Labour, Social Relations, Family and Solidarity

Address: 127, rue de Grenelle, 75007 PARIS 07 SP, France
Webpage: http://www.travail-solidarite.gouv.fr/

Ministère de la Santé et des Sports

Address: 14, avenue Duquesne, 75350 PARIS 07 SP, France
Phone: + 33 (0) 825 302 302
Webpage: http://www.sante-jeunesse-sports.gouv.fr/

L'Observatoire des Retraites – Pensions Observatory

Address: 16-18 rue Jules César, 75012 Paris
Phone: 0033 1 71 72 12 00
Webpage: http://www.observatoire-retraites.org/

The Observatoire des Retraites has been created in 1991 by Agirc and Arrco schemes. Its main objectives are to:

- *promote studies and analyses of the French pension system and of foreign pension systems*
- *improve access to reliable and non-partisan information on pension systems.*

The main publication of the Observatoire des Retraites is the "Lettre de l'Observatoire des Retraites" which is published several times every year.

Observatoire Français des Conjonctures Economiques (OFCE) – The French Economic Observatory

Address: 69 quai d'Orsay, 75340 Paris cedex 07
Phone: 0033 1 44 18 54 00
Webpage: http://www.ofce.sciences-po.fr

The OFCE is both a university research centre and an institution for forecasting and evaluating public policies. It brings together over 40 French and international researchers, including several internationally renowned research fellows and three Nobel Prize laureates. The OFCE is organised into four departments – Analysis & Forecasting, Research, Innovation & Competition, and Globalisation. The OFCE publishes both a quarterly review ("Revue de l'OFCE") and a monthly newsletter ("Lettre de l'OFCE") with in-depth analyses of pertinent subjects and issues of debate, as well as working papers. The Observatory also publishes annually several documents that bring together contributions from its specialists: L'Économie française, L'état de l'Union européenne, and the Report on the State of the European Union.

Secrétariat général du Conseil d'orientation des retraites Conseil d'Orientation des Retraites (COR) – Pension Orientation Council

Address: 113, rue de Grenelle, 75007 Paris
Phone: 0033 1 42 75 65 50
Webpage: http://www.cor-retraites.fr/index.php

The COR is a structure created by the Jospin Government in 2000 that gathers representatives of the main stakeholders in the pension system (trade unions, employers' associations, pensioners' organisations, family associations, MPs, civil servants, directors of public pension administrations as well as experts). COR regularly feeds the pension debate by publishing reports and documents that are considered as highly reliable and serve as a basis for the preparation of pension reforms. All COR documents are publicly available on the internet.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en