EUROPEAN FACT FILES

HEALTH AND SOCIAL CARE REPORT

2020

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Contents

The emergence of a new coronavirus in China at the end of 2019 did not immediately cause much alarm. Yet, within three months, governments around the world had enacted policies that have almost no precedence in the modern age. Airplanes were grounded across the globe, movement of people restricted, and stock markets sank to levels not seen for more than a decade. By May, Covid-19 is reported to have accounted for over 200,00 deaths worldwide – and likely many more remain unattributed.

Amidst the uncertainty and economic turmoil, the pandemic has had significant impacts on European health and social care services. The sector has taken centre stage in the public and political consciousness and has been forced to rapidly adapt in the face of new challenges. System transformations that had spent years blocked by organisational inertia have been rolled out in a matter of weeks, and public and private sector working dynamics have been dramatically reshaped.

Unlike the uncertainty that surrounds many sectors, health and social care has remained active during this crisis and must surely emerge in a position of relative strength. In Europe, the immediate focus of every government's response has been to ensure national health systems do not collapse under the weight of demand. Where other sectors have gone into reverse, health and social care has gone into overdrive. In the longer-term, the challenges presented by the pandemic could profoundly reshape the policy, reimbursement and regulatory drivers that influence the health and social care landscape.

The Return of Interventionist Governments

As the number of cases rose in Europe, we have seen a return to interventionist policy-making. Whilst recessions may have hit hard in the past, they were not accompanied by the societal-wide disruption brought on by the emergence of a global health threat. With every aspect of the economy impacted, governments have wielded their authority with a power rarely seen as permissible in a democracy.

Citizens in Europe's liberal democracies are facing mandatory restrictions to their everyday life unlike anything they will ever have experienced. Meanwhile governments across the continent have opened their chequebooks to pump money directly into the health and social care system, whilst also propping up the wider economy to reduce the likelihood that the inevitable recession becomes entrenched.

Healthcare systems have received multi-billion cash injections to ensure that staff and equipment are on hand. Centralised planning has taken over from local decision-making in many countries, and governments across Europe have employed a mixture of tactics to ensure private sector health providers are directly supporting Covid-19 responses. Elective surgeries – a mainstay of independent hospitals – have been cancelled to release capacity, and private sector has been co-opted to support the surge in demand in acute care.

The Road to Recovery

With the outbreak having seemingly peaked in Germany, Spain and Italy – and France and the United Kingdom appearing to be reaching this point – decisions around relaxing national lockdowns are now having to be made.

As summer approaches and temperatures rise, pressure to relax strict restrictions will increase, and there will need to be careful political calculation along how long a lockdown can feasibly be maintained. However, this will need to be balanced against the risk of a second wave of infections threatening to undo much of the good work achieved so far.

At present, the most likely route out is focused on a staggered opening of the economy. Sectors deemed essential to society are likely to be prioritised, with an expectation that those that lead to mass gatherings may be forced to remain closed for much longer.

Testing availability may be critical, and the shortage of PPE is likely to remain a challenge. This will be exacerbated if testing is required for industries to return to work, or if commuters are expected to wear face masks when using public transport.

Meanwhile, civil liberty groups have already expressed concerns over the use of personal data within tracking apps - the use of which has been credited with playing a major role in containing the outbreak in South Korea.

This illustrates the challenges faced by governments across Europe as they are forced to balance the competing demands of their citizens. Whereas there was a strong political consensus during the crisis management phase, this may begin to dissipate as tough decisions that require trading public health for economic recovery need to made.

Longer-Term Challenges for Healthcare Systems

European governments will face tough choices in the aftermath of the pandemic. After a decade of public spending restraint in the wake of the 2008 financial crisis, spending on public services and infrastructure was finally beginning to rise again. Governments risk a political backlash if, after spending many months forced to stay at home, people are then told that vital public services face cuts. However, with economies on their knees following the enforced shutdown of many sectors, governments are likely to feel they have limited scope for raising taxes.

Health and social care could be one of the publicly funded sectors protected from funding cuts. The sacrifices made by the workforce have not gone unnoticed by the public, and it is questionable whether a government would be willing to gamble their political capital on policies that risk accusations of under-funding.

Although organisations have rightly focused on tackling short-term challenges to ensure operational responsiveness during the pandemic, it is critical to understand how these play out over the longer-term from an investment perspective.

Each sector faces its own unique challenges, and the responses to these will be fundamentally shaped by policy, reimbursement and regulatory levers enacted by national governments. To support investors, Marwood has identified some common themes likely to have critical impacts on private providers. In the graphic below we identify four critical issues, and key questions that investors ought to be considering.

Critical Issues and Key Questions Facing Health and Social Care Post-Pandemic

System Transformation

- The requirement to ensure public health systems could meet demand has led to large scale changes in operating procedures
- Covid-19 has led to a massive and rapid shift to digital first primary care services
- Rapid acute discharge is possible if rules and regulations are eased
- Private sector capacity has been diverted to support the public sector

Will these changes be embedded and lead to rapid adoption of new ways of working that the private sector can support public health systems to deliver?

Public Spending Pressure

- European countries have placed huge pressure on their finances to prop up the economy during the crisis
- Countries were only just emerging from a decade of spending restraint, so further cuts may be challenging
- Tax rises may be required - but will require careful consideration in order to be viewed as politically acceptable and not damaging to the economic recovery

Even if public sector spending cuts are required, will any government feel able to reduce spending to health and social care sectors?

Social Care Sustainability

- Enduring social care sustainability against a backdrop of an ageing population remains a challenge across Europe
- The pandemic has revealed the fragility of social care - and how it often struggles for recognition against competing healthcare claims
- Since all solutions require individuals to either pay more through tax, insurance or self-funded support, politicians have often been keen to avoid the issue

Will Governments use the crisis as an opportunity to have an honest conversation with the public about the need to reach an agreement on how future social care needs should be funded?

Managing Pent-up Demand

- Health systems were already under pressure before the emergence of Covid-19, with many countries focussing on reducing waiting lists as a key health priority
- With routine elective surgery cancelled, existing wait lists have frozen - whilst demand from new patients will only grow
- As systems revert to normal, there will be large pent-up demand to resolve an exhausted and depleted workforce to deliver them

Given the lack of capacity in the public sector, what role can the private sector play in reducing the waiting lists for those waiting months for elective care?

Europe and the Rise of the Cross-Border Consumer

Across the European Union (EU), more than 25 million people are affected by infertility. To place this number in context, it is equivalent to the combined populations of Denmark, Norway, Sweden, and Finland. It does not even begin to include those in gay, lesbian or alternative relationships that would like to have children of their own, but live in countries where assisted reproduction treatments are legally unavailable to them.

The past 50 years has seen a vast expansion in assisted reproductive technology (ART) options, and these services are widely offered across Europe. However, it is here that scientific advancement clashes with national policy decisions, as frameworks regulating fertility differ widely country to country. This leads to significant differences in who can access treatments, and the services available to them, depending on where they live.

However, wider advancements in the 21st century have reframed the fertility debate. Individuals are increasingly becoming more empowered over their healthcare decisions, and freedom of movement across the EU means that where these are not aligned to individual expectations, people have the freedom to look to neighbouring countries for services they cannot access in their own. This creates favourable conditions for the emergence of fertility tourism for those that can afford it.

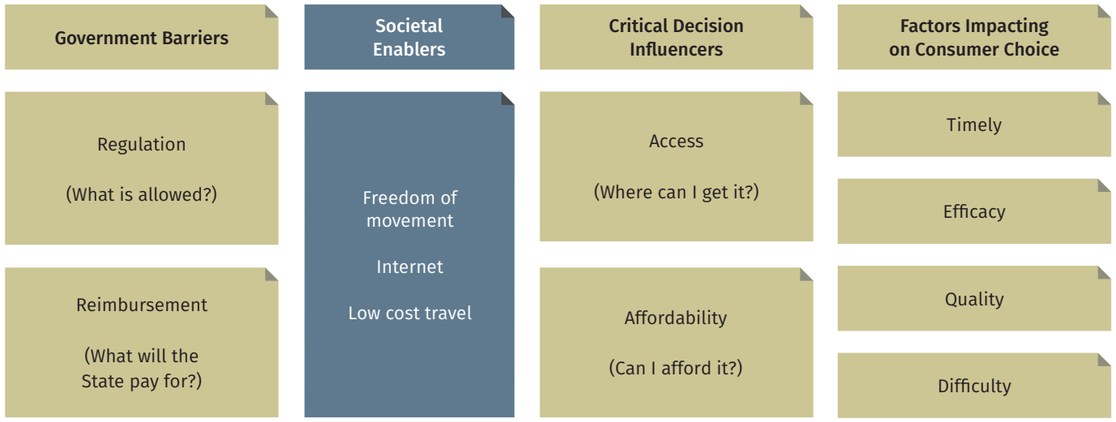
How Government Decisions Frame Fertility Options

Public healthcare systems will always be unique; they are shaped by politicians, policymakers and public expectations of what a healthcare system funded by the people should offer. Though there may be broad agreement over emergency services, hospitals and primary care provision, there can be substantial differences for anything not seen as an essential service.

This goes even further with ART solutions, as it introduces moral and ethical arguments into the equation. Egg donation is currently illegal in both private and public provision in Germany, but in the UK, Spain and France, it is allowed – so long as it is altruistic and not commercial. Access is also dictated by the generosity of public healthcare system reimbursement, and the type of individuals who are legally entitled to access ART services (reimbursed or not).

Ultimately, governments must answer two critical questions, which fundamentally influence the decision of whether a person will need to consider cross-border treatment.

- What the Government believes should be freely available, and to whom (regulation)
- What the Government should pay for on behalf of the individual, and how the available resources will be allocated (reimbursement)



The importance of understanding a country's socio-political dynamic cannot be overstated – Poland provides an interesting case study of how politics can shape provision. The election of the Law and Justice Party in 2015 saw a radical revision of existing IVF laws, ending fertility reimbursement only two years after it was introduced, citing costs grounds. But momentum had begun even earlier, with the party clearly using it as an electoral strategy in opposition in order to gain favour with socially conservative and religious groups within the country.

The Polish example reminds us that legislative, regulatory and reimbursement frameworks are not static. They may evolve in line with or against changing societal attitudes and as a result these access conditions can change.

Across the five largest EU countries, the UK and Spain currently offer the largest choice of services to the widest group of people. France, Germany and Italy are still some distance away from the liberal frameworks in countries like the UK, Spain, Belgium, Sweden and Denmark. However, with continuous changes in social and cultural attitudes, policymakers and regulators across Europe will have to adapt to remain aligned with the views of their electorate.

Fertility preservation is likely to become increasingly central to the debate. Some countries currently only authorise egg freezing for medical reasons. But will this restriction continue to be justified in the wake of debates over gender equality, and more women looking to find the best way to balance a fulfilling career and a family life? Many of these new challenges have an ethical dimension, and some of these techniques are unlikely to be politically acceptable in more conservative European countries. The fact that these questions remain, and that countries will have their own solutions to them, suggest that opportunities arising from cross-border consumer flows will continue for some time.

Understanding Drivers Behind Cross-Border Treatment

Tracking cross-border movements of fertility consumers is challenging. Whilst fertility providers will have recorded Intended Parents' nationalities during the treatment process, they do not need to provide access to this information. Meanwhile regulatory requirements to monitor the nationality of intended parents vary from country to country.

As fertility solutions emerge across Europe, it is possible to see the organic creation of value propositions unique to countries. This may not seem unusual to those who have already invested in traditional consumer healthcare platforms – such as cosmetic dentistry and aesthetic treatments – but it is vital to realise that consumers are not just factoring price and quality concerns into their decision-making, they are also navigating legal restrictions that will make certain services unavailable in some countries.

Marwood's work in the fertility space has allowed us to identify key drivers for destination countries. We know that if they can afford it, many consumers would choose the United States for treatment. US-based providers tend to offer a high-quality service, without restrictions that can exist in Europe – critically, commercial surrogacy and gender selection are legally available, which can be key factors for some individuals. However, affordability is a big barrier for accessing US-based treatment – a basic cycle package with very few additional services can cost upwards of €12,000, compared to around €5000 at a leading Spanish clinic.

Within Europe, it is important to remember that cost and quality are relative whilst service availability is fixed. Spain is cheap compared to the United States, but expensive compared to services based in central and eastern Europe.

Regulatory divergence within Europe has led to countries gaining a reputation for meeting specific socio-cultural preferences. If commercial surrogacy is a requirement then there are only three countries in Europe that will be appropriate. Similarly, restrictions on gender selection, anonymous donations, or upper age limits for the intended parent factor will all factor into decision-making.

A single-country provider's service offering will be restricted by national legislation. However, operating across multiple territories allows for signposting clients to a provider's alternative provision where services may not be restricted through legislation or regulation, or where they are more likely to be able to meet a person's individual requirements.

Healthcare System Snapshot

	HEALTHCARE			
	Publicly Funded Healthcare Safety Net	Sources of Funding For Public-Pay Healthcare	Primary Payers	Provider Ownership
Belgium	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions, National Taxation	7 Sickness Funds	Majority Public and Non-Profit, Small Private Sector
Denmark	National Health Service Universal Access	National Taxation	5 Regions	Majority Public, Small Private Sector
Finland	National Health Service Universal Access	National and Local Taxation	311 Municipalities	Majority Public, Small Private Sector
France	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions, National Taxation	Central Statutory Health Insurance	Public and Private Mix
Germany	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions	109 Sickness Funds	Public and Private Mix
Ireland	National Health Service Access Means Tested	National Taxation	Health Service Executive, Individuals	Public and Private Mix
Italy	National Health Service Universal Access	National Taxation	21 Regional Local Health Authorities	Majority Public, Small Private Sector
Netherlands	Statutory Health Insurance Universal Access	Employee/Employer Payroll Contributions	Sickness Funds	Majority Public and Non-Profit
Poland	National Health Service Universal Access	Earmarked National Taxation	National Health Fund	Majority Public, Small Private Sector
Portugal	National Health Service Universal Access	National Taxation	NHS, Ministry of Health	Public and Private Mix
Norway	National Health Service Universal Access	National and Local Taxation	4 Regional Health Authorities	Majority Public, Small Private Sector
Spain	National Health Service Universal Access	Local Taxation	19 Regional Health Services	Public and Private Mix
Sweden	National Health Service Universal Access	Local Taxation	21 County Councils	Majority Public and Non-Profit
Switzerland	Statutory Health Insurance Universal Access	Statutory Health Insurance Premiums, National and Local Taxation	Sickness Funds, 26 Cantonal Health Authorities	Public and Private Mix
England	National Health Service Universal Access	National Taxation	135 Clinical Commissioning Groups	Majority Public, Small Private Sector
N. Ireland	National Health Service Universal Access	National Taxation	Health and Social Care Board	Majority Public, Small Private Sector
Scotland	National Health Service Universal Access	National Taxation	14 NHS Boards	Majority Public, Small Private Sector
Wales	National Health Service Universal Access	National Taxation	7 Local Health Boards	Majority Public, Small Private Sector

Social Care System Snapshot

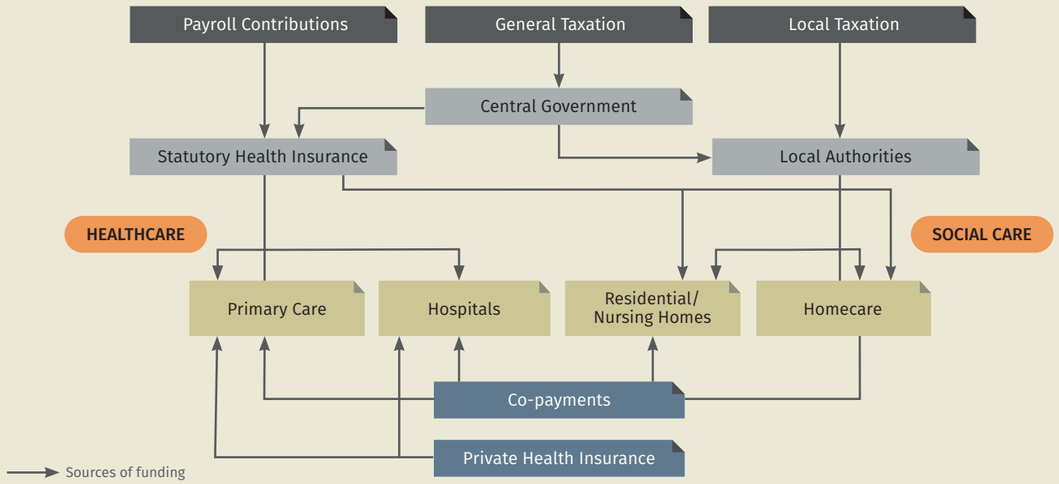
	SOCIAL CARE			
	Public Social Care System: Access Criteria	Public Social Care System: Sources of Funding	Primary Payers	Social Care Providers
Belgium	Need and Means-Test	National and Local Taxation	7 Sickness Funds, Regions, Individuals	Public and Private Mix
Denmark	Need-Test	Local Taxation	98 Municipalities, Individuals	Majority Public, Small Private Sector
Finland	Need and Means-Test	National and Local Taxation	311 Municipalities, Individuals	Majority Public, Small Private Sector
France	Need and Means-Test	National and Local Taxation	101 Local Authorities, Statutory Health Insurance, Individuals	Public and Private Mix
Germany	Need-Test	Employee/Employer Payroll Contributions to Long-Term Care Insurance	109 Long-Term Care Funds, Individuals	Majority Private
Ireland	Need and Means-Test. No Statutory System for Homecare	National Taxation	Health Service Executive, Individuals	Public and Private Mix
Italy	Need and Means-Test	National and Local Taxation	Over 7,000 Municipalities, 103 Local Health Authorities, Individuals	Majority Public, Small Private Sector
Netherlands	Need and Means-Test	Employee/Employer Payroll Contributions to Long-Term Care Insurance	380 Municipalities, Sickness Funds, Individuals	Majority Non-Profit
Poland	No Statutory System Defining Access Criteria	Earmarked National Taxation, Regional and Local Taxation	National Health Fund, Sub-national Governments, Individuals	Majority Public, Small Private Sector
Portugal	Need and Means-Test	National Taxation	Ministry of Health, Ministry of Labour and Social Solidarity, Individuals	Majority Non-Profit
Norway	Need and Means-Test	National and Local Taxation	422 Municipalities, Individuals	Majority Public, Small Private Sector
Spain	Need and Means-Test	National and Local Taxation	19 Regions, Individuals	Majority Private
Sweden	Need-Test	Local Taxation	290 Municipalities	Public and Private Mix
Switzerland	Need and Means-Test	Statutory Health Insurance Premiums, National and Local Taxation	Sickness Funds, 26 Cantons, Municipalities	Public and Private Mix
England	Need and Means-Test	National and Local Taxation	152 Local Authorities, Individuals	Majority Private
N.Ireland	Age, Need and Means-Test	National Taxation	Health and Social Care Board, Individuals	Majority Private
Scotland	Age, Need and Means-Test	National Taxation	32 Local Authorities, Individuals	Majority Private
Wales	Need and Means-Test	National and Local Taxation	22 Local Authorities, Individuals	Majority Private

France

Key Messages

- The Government has delayed legislation underpinning comprehensive social care reforms, despite having indicated support. It is now expected in the second half of 2020, but that timeline must come under question given the disruption caused by Covid-19
- Under the proposals, the range of services available to older people would be expanded. There is a particular focus on facilitating the integration of nursing and activities of daily living homecare services. The need to modernise and enhance nursing home services is an equally important priority – meaning there could be opportunities for existing providers to expand
- The recommendations also address the complexity faced by users when they need to access public funding support to pay for their care, with proposals to simplify how people apply for funding – this would likely improve access to formal care services
- In the short-term, nursing home providers may be able to bid for refurbishment grants and access funding to increase staff numbers. This money will be available until 2021-2022. Longer-term solutions require legislative changes
- Healthcare reforms are ongoing to increase access to services in the community. Over the next two years, this will see the role of community hospitals expanded to offer intermediate lower acuity services to older people, those suffering from chronic diseases and pre and post-natal follow-up
- Online GP consultations have been covered by Statutory Health Insurance reimbursement since the end of 2018, but take-up had been low. In the wake of the Covid-19 outbreak, the Government's relaxation of reimbursement conditions may accelerate online consultation penetration

Funding Flows



Source: Marwood

Population

Source: Eurostat (2018)

Total

67.2m

Life Expectancy

82.4 years

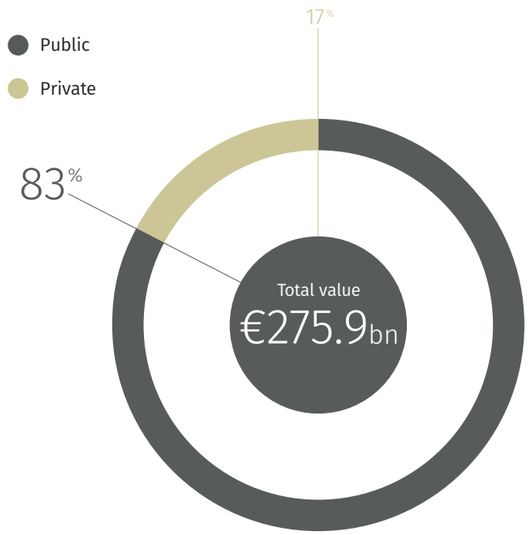
Population Distribution (%)

- 30.2% are aged between 0 and 24
- 50.6% are aged between 25 and 64
- 19.2% are aged over 65

Selected Health and Social Care Data

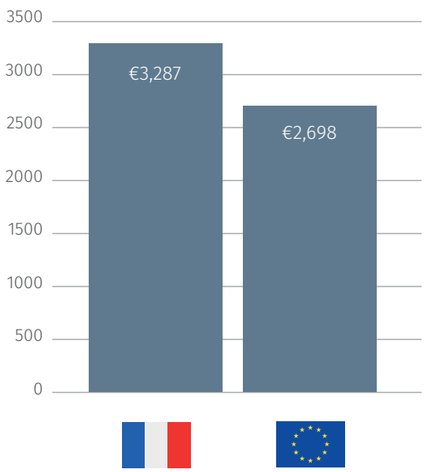
Healthcare Expenditure (2018)

Source: OECD



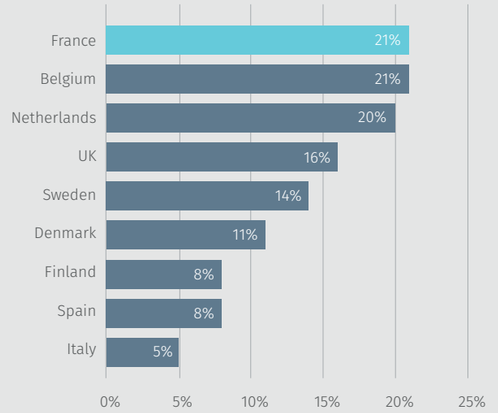
Public Health Spending Per Capita (2018)

Source: OECD



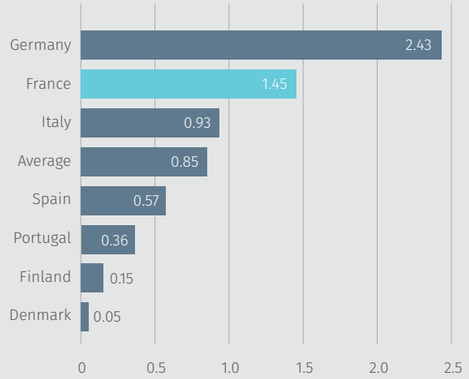
Public healthcare expenditure per capita is 22% higher than the EU average.

Percentage of older people over 85 year-old living in nursing homes



France has one of the highest proportion of over 85s living in nursing homes

Number of private hospital beds per 1000 population (2017)



France has more private hospital beds per capita than the European average

Sources: OECD, Eurostat

Comprehensive and ambitious proposals to reform older people's care await implementation

The Libault Report published in March 2019 outlined 175 recommendations to reform the French social care system for older people and address challenges posed by the ageing population. Key themes including reorganising financial support mechanism for individuals, developing homecare services while modernising nursing homes and diversifying their service offering – for example to include supported accommodation or day services.

Primary legislation is required to implement core aspects of the report, such as reforming the law around homecare to make it easier for providers that offer both nursing care and activities of daily living support services. Currently, the requirement for a separate legal status means it is complex to integrate these services. This could help resolve market fragmentation by creating opportunities for consolidation among smaller providers and scaling-up in the homecare market, where demand for services is expected to grow.

The Government has given every indication that older people's care reform would remain a central priority. However, the release of the Bill on Independence in Old Age has been delayed to the Summer of 2020. Recent political turmoil around a reform of the pensions system could have a knock-on impact and further delay the Bill – whilst the emergence of Covid-19 is likely to throw the timeline into question.

Despite the absence of legislative proposals yet, some funding has been allocated. It primarily addresses the refurbishment of nursing homes, with €100m per year between 2019 and 2022. The Social Security Funding Act 2020 also allocated €500m in 2020-2021 for the recruitment of additional staff in nursing homes.

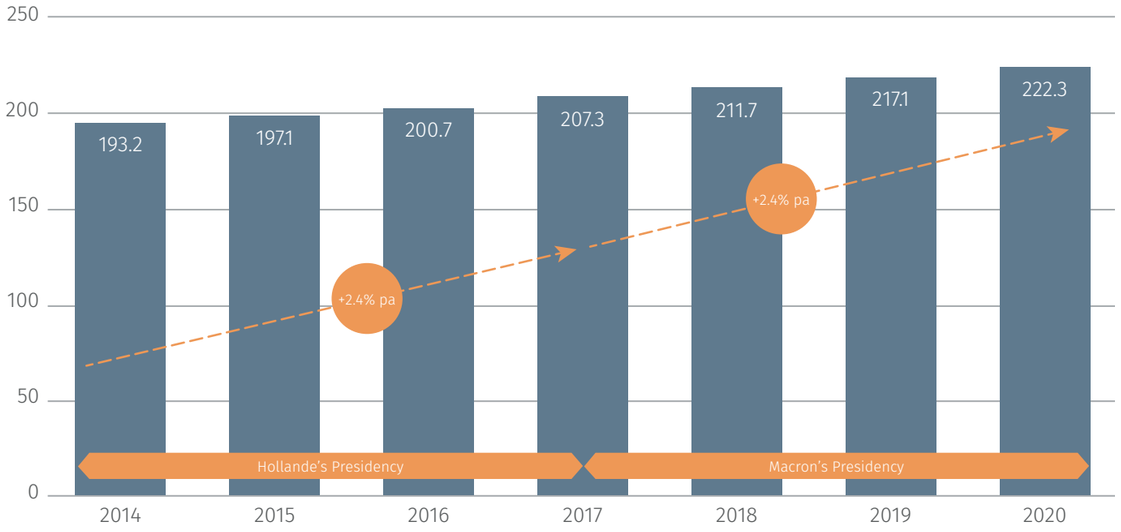
Funding

Healthcare funding is primarily public and comes from mandatory payroll contributions to the Statutory Health Insurance (SHI). Increasingly this is topped-up by general taxation revenue allocated by central government.

The SHI budget is set on an annual basis by parliament. This budget has been growing just over the rate of inflation at an average of 2.4% annually between 2014 and 2020. Growth is overall consistent and there has not been any change in the average annual budgetary increases since the last Presidential election and change of Government in 2017.

SHI Budget (€, bn)

Source: Social Security Funding Act, Ministry of Health



Payment System

Reimbursement rates to providers are set nationally by the Ministry of Health and the SHI, in negotiation with the National Union of Health Professionals.

However, provider reimbursement is complex. Whilst the SHI ultimately covers the majority of healthcare costs, individuals may be required to pay for services before claiming these expenses back from the SHI and their complementary private health insurance (PHI). There are also differences between primary care and hospital reimbursement mechanisms.

In primary care, GPs are paid directly by patients, who then claim the expense back from the SHI and complementary PHI. The current price of a visit is €25, of which €1 cannot be claimed back. In addition, the SHI makes direct capitated payments GPs for the management of chronically ill patients.

Since the end of 2018, online GP consultations are also covered by the SHI, as long as the patient is either registered with the GP or has seen the GP at least once in the past 12 months. These consultations cost the same as face to face consultations. Initial take-up has been lower than the Government expected – over the first year, 60,000 online consultations took place against an objective of 500,000. However, the Covid-19 outbreak may have forced acceleration. The Government relaxed reimbursement conditions, extending coverage for all online consultations.

Hospitals are paid directly by the SHI based on a Diagnosis Related Group (DRG) system. In recent years, new payment mechanisms have been developed, including payment for performance and activity-based payments. There are limited patient co-payments for the cost of food and accommodation.

The role of voluntary private health insurance in France

As SHI does not cover all healthcare costs, individuals are strongly encouraged to subscribe to complementary private health insurance, which covers eligible remaining costs, such as GP or specialist visit. The tariffs for these costs are set nationally. Over 95% of the population is now covered. This is a result of reforms requiring all employers to purchase complementary health insurance for their employees and cover at least 50% of the costs.

Complementary insurance plans may also offer supplementary insurance, covering for example upgrades to a single hospital room. Some plans also cover services that are not covered by the SHI, like osteopathy or some vaccines. Overall, voluntary private health insurance does not provide faster access to services.

Provider Landscape

Healthcare services are delivered by a mix of public and private providers. Primary and specialist outpatient care is mostly provided by independent, self-employed professionals in private practice. They increasingly work in primary health centres with other healthcare professionals, as mandated in national policy.

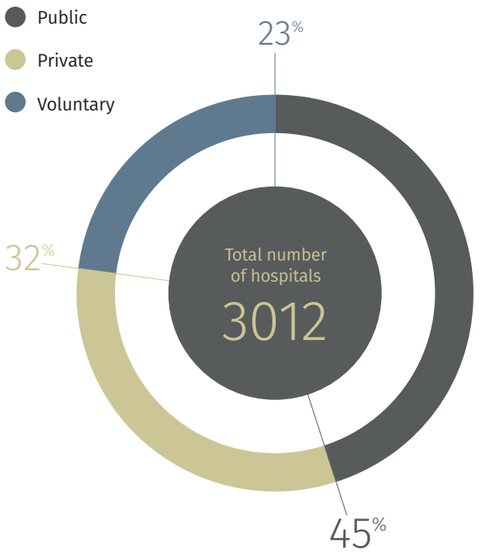
Secondary care services are primarily delivered by public hospitals complemented by private clinics. 1351 (45%) of hospitals are public, 975 (32%) are private and 686 (23%) voluntary (the main providers of cancer treatment). Private for-profit hospitals are found in greater numbers around Paris, the Loire Valley, the South East and Corsica.

The public hospital sector has been significantly reorganised. Over 1300 public hospitals now operate as part of one of the 135 Hospital Groups. These structures have been established since 2016 in order to increase savings and efficiency, primarily through pooling back-office functions, such as procurement. Increasingly, they are also sharing clinical functions, like clinical biology laboratories and diagnostic imaging platforms. All public hospitals must use their Hospital Group's services and resources before turning to external providers. However, private hospitals can work in partnership with Hospital Groups, to complement their services. Needs for cooperation are defined at the local level, within each Hospital Group's catchment area.

The Health Act 2019 gave a new impulse to healthcare services reorganisation, focusing on expanding the role of community hospitals. These hospitals already exist and tend to be smaller, local hospitals. The reform seeks to strengthen their role. They will stand at the crossroad between primary care and traditional hospital care, providing a range of clinical services including geriatric services, pre and post-natal services, and management of chronic diseases. Under certain conditions, they may also provide a limited range of elective care operations. By 2022, 500 to 600 hospitals are expected to be accredited to operate as community hospitals – both local public and private hospitals can apply for the status.

Healthcare

Hospital Ownership



Regulation

Healthcare services are regulated by the Health Authority. In order to operate, public and private healthcare providers must obtain a certification from the Health Authority. There are different certifications procedures for hospitals and for primary care services. Hospitals are re-evaluated every four to six years, while primary care professionals benefit from a lighter certification process.

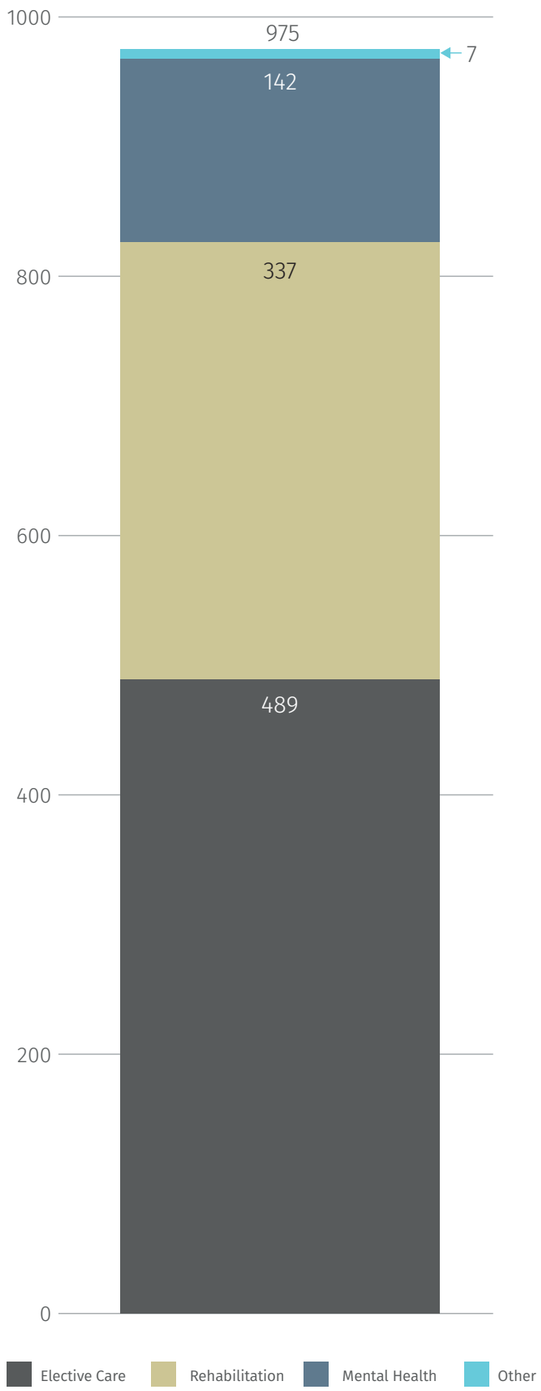
The Health Authority has reviewed the hospital certification procedure for public and private hospitals. Inspections following the new certification indications will start from the second half of 2020, and will increase the focus on:

- Clinical outcomes
- Quality standards
- Patient-centred care

Recent legislative changes have sought to improve the quality of care, patient rights and safety. In addition, the Healthcare Transformation Strategy opened a consultation on the development of indicators to evaluate the quality of pathways for common diseases, such as diabetes. The Health Authority is currently working on the development of these indicators.

Private Hospital by Service Type

Source: Ministry of Health



Social Care

Funding

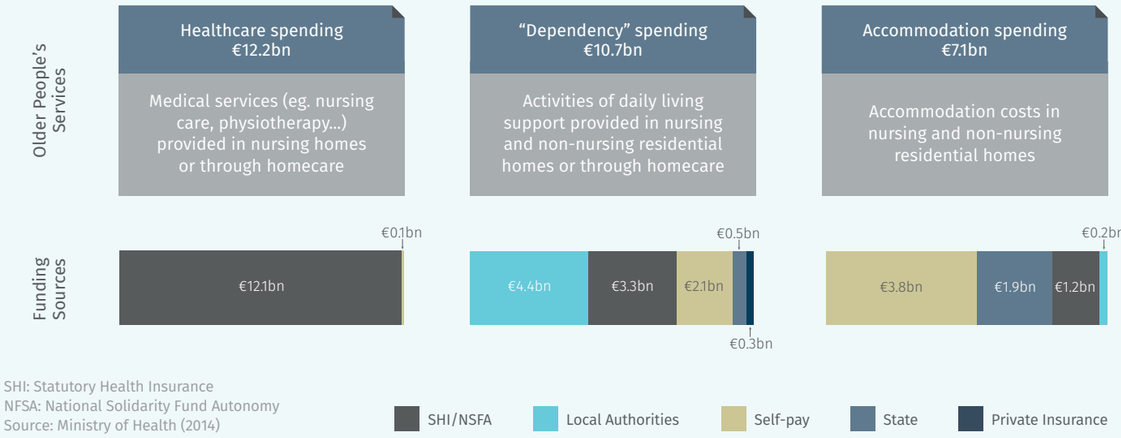
Publicly funded social care covers homecare and residential nursing home services for adults and older people.

Public funding for these services relies on a complex mix of local and national revenue sources. The responsibility for funding social care services lies with local authorities. Local authorities allocate social care resources within their wider budgets, alongside other local services.

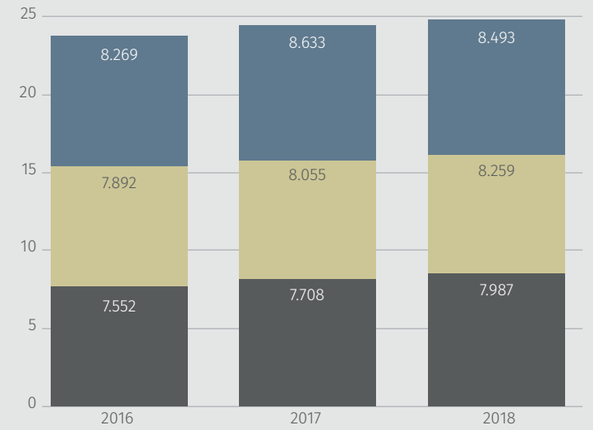
In 2018, the total budget of local authorities was €69.1bn, of which €24.7bn was dedicated to funding social services for children, adults and older people. 65% of local authority budgets come from local taxation. Other sources of local authority funding include central funding, and some SHI funding.

In recent years, central government has allocated additional funding to social care on an ad-hoc basis. This funding is primarily directed at supporting care homes. For example, there is €100m per year between 2019 and 2022 to finance nursing home renovations and €500m in 2020-2021 for the recruitment of additional staff in nursing homes. More measures are expected to be announced in the Bill on Independence in Old Age, and should address long-term funding, prevention, expanding homecare provision, and quality improvement.

Sources of Funding for Older People's Care



SHI: Statutory Health Insurance
NFSA: National Solidarity Fund Autonomy
Source: Ministry of Health (2014)



Publicly Funded Social Care (€,bn)

Source: Ministry for Local Communities

- Children
- Physical and learning disability
- Older people ('dependency' funding)

Payment System

Social care payments are split across public and private sources. Providers receive payments from both public and private sources as individuals are expected to contribute towards the cost of their care. The local authorities are the main public payer. Nursing home prices are calculated on the basis of two elements:

- Dependency tariff: in 2017, the median tariff varied between €5.47 and €20.35 per day. It covers the costs of support with activities of daily living in a care home. This tariff is set by local authorities, updated every year and applies to all nursing home beds
- Accommodation and board tariff: in 2017, the median rate was €59.44 per day. It is negotiated between local authorities and providers and is updated each year in accordance with a nationally set uplift. This tariff applies to beds commissioned by local authorities, while tariffs for private beds can be set freely by providers

In addition, the SHI pays for the cost of medical care delivered in care homes, and nursing care services delivered at home.

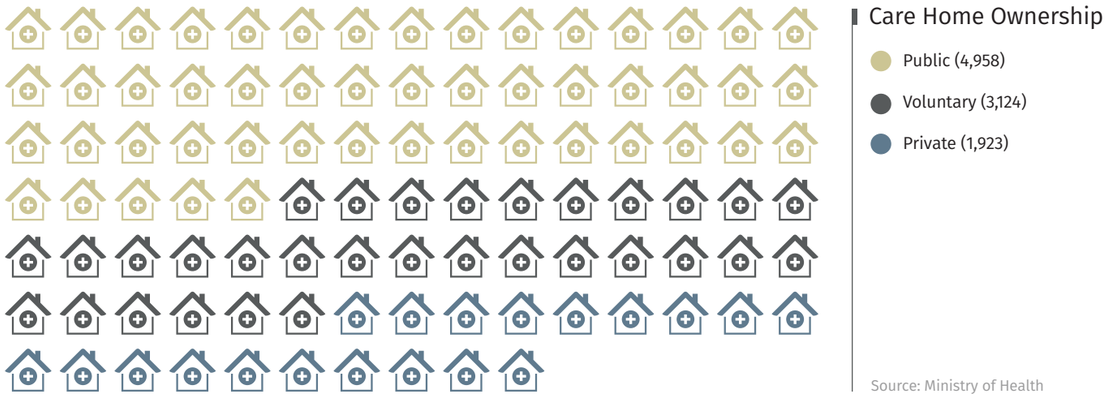
Local authority payments for support with activities of daily living services delivered at home can be made to individuals, who then purchase services from their chosen provider, or directly to providers. The amount paid by local authorities is needs and means tested, with individuals expected to make co-payments when monthly income exceeds €810,96. For services commissioned by local authorities, tariffs are agreed with each individual provider.

Provider Landscape

Social care services are delivered by a mix of public and private providers. Historically, providers were mostly public. Legislative changes have enabled more private provision, and the number of private providers is increasing.

Homecare services include support for activities of daily living, medical homecare, or sometimes a mix of both. In 2016, there were 34,902 providers of homecare services.

Care homes include residential homes and nursing homes. There are also day-care and short-term rehabilitation services, which can be used to step down from hospital care. In 2015, there were 10,005 care homes for older people. 7,400 of them were nursing homes, providing medical services for older people who are dependent. The majority of providers are publicly owned or not for profit.



Orpea Groupe: an example of a social care provider with a diversified portfolio of services, aligned with emerging policy objectives for older people's care

Orpea Groupe is one of the largest providers of social care in France. The company was founded in 1989 and now operates 354 facilities and over 33,000 beds in France. Orpea provides services to both publicly and privately funded individuals. The service offering spans:

- Long term care and medical nursing homes
- Post-acute care and rehabilitation facilities
- Psychiatric clinics
- Homecare services
- Independent living accommodation

Adult social care in France is funded in most part by public budgets, drawing from multiple sources. There is also a self-pay top-up element which is expected to cover services not covered by social care and for board and accommodation. Per capita disposable incomes in France are approximately 13% higher than the EU average, standing at €28,780 per annum. This implies personal affordability of care is potentially better than most other EU countries.

Orpea's service mix is well suited to respond to recommendations of improving older people's care outlined in the Libault Report, and expected to be included in government legislation towards the end of 2020. It recommended that while nursing home services should be maintained and expanded to respond to future needs, whilst also developing alternative services. There is a strong focus on increasing availability of independent living accommodation, as well as expanding homecare service provision.

This is aligned with the strategy of some social care providers like Orpea, of providing a host of services to suit the needs of an individual and integrating care across nursing care and activities of daily living home care. Groups that can deliver an integrated offering are likely to benefit from the proposed systemic improvements in social care in France.

Country	Facilities	Beds
France	354	33,443
Spain	62	10,428
Germany	180	19,075
Austria	84	7,474
Belgium	61	7,437
Netherlands	67	1,830
Poland	22	2,745
Czechia	19	2,698
Italy	21	2,649
Switzerland	37	3,695
Portugal	22	2,296
Brazil	18	2,752
China	1	140

Regulation

Since 2018, the Health Authority is responsible for regulating social care services. Previously, regulation had been the responsibility of the National Agency for the Quality Assessment of Health and Social Care Organisations. This organisation has now merged with the Health Authority.

The Health Authority is currently developing a common evaluation reference document for all providers. This is intended to harmonise evaluation processes and providers will be able to use the reference document as a template instead of having to develop their own systems. The Health Authority is also working on developing new best practice guidelines and setting-up a range of indicators to measure user satisfaction with social care services.

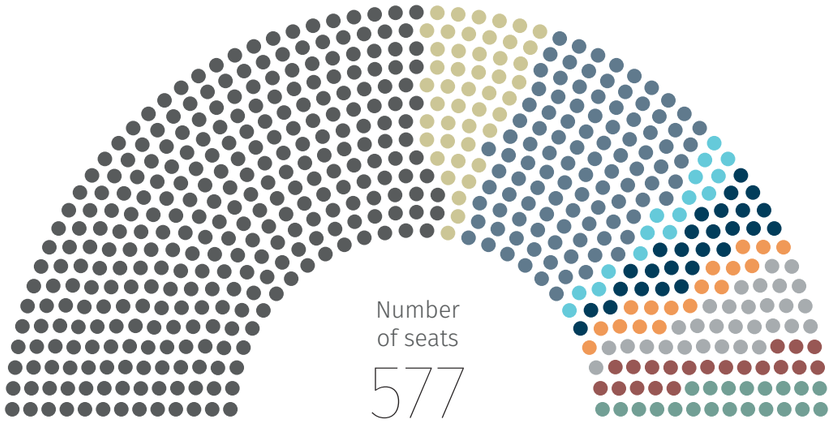
There are currently no planned changes to the way providers that contract with local authorities are evaluated. Evaluations will continue to be carried out internally by social care providers and externally by accredited inspection bodies. Most provider authorisations are granted for 5 years.

Political Environment

The current president, Emmanuel Macron was elected in May 2017. His Government, led by Prime Minister Edouard Philippe, has the support of his centrist party, “Republic on the Move”, in the National Assembly. This facilitates the passing of legislation – despite the withdrawal of support from 16 MPs, Macron still enjoys a parliamentary majority, albeit a short one.

The wave of public protests that started in November 2018 shook-up the political agenda, with draft legislation on transport and local administration re-organisation put on hold. Initially targeting the rising cost of living and fiscal policy, protests have expanded to cover nearly all policy areas. In response, the President launched a national consultation which placed access to public services as a key concern for the French people. The political commitment to reform older people’s care and improve services needs to be understood in this context. However, the launch of the legislation to reform of the complex pension system at the end of 2019 led to another wave of protests and demonstrations, and delayed other legislative reforms. The isolation measures imposed in the wake of Covid-19 have dampened all protests, and it remains to be seen whether these re-emerge once movement restrictions are lifted.

The president and members of the National Assembly are elected every five years. The next elections are due to take place in Spring 2022.



Composition of Parliament

Government

- Republic on the Move (296)

Support to Government

- Modem (46)

Opposition

- Republicans (104)
- Democratic and Republican Left (16)
- Independents (27)
- France Insoumise (17)
- Socialists (30)
- Territories Freedom (20)
- Others (21)

Contact us

For more information on any of the content in this publication or to learn more about Marwood Group Advisory’s capabilities, we encourage you to please contact us.

Jyoti Mehan
Director, Business Development
Office: +44 (0)20 3178 2504
jmehan@marwoodgroup.com