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How to Explain Why so Few Individuals Insure themselves against the Risk of Old-age Dependency?

A Review of the Literature

Roméo Fontaine (LEG, University of Burgundy; IRDES; Médéric Alzheimer Foundation)
Nina Zerrar (LEDa-Legos, Paris-Dauphine University)

In France, the financing of long-term care (LTC) for elderly dependent persons is organised around three main institutions: the family, the Government and the market. As it may prove difficult to make additional demands on social and family solidarity to meet increased long-term care needs, the question has been raised as to the future role that could be played by the LTC insurance market. Paradoxically, despite the excessive out-of-pocket payments incurred by the consumption of long-term care, that can amount to tens of thousands of euros, the majority of individuals are not insured against the risk of old-age dependency.

This review of the literature provides a synthesis of the various disincentives to voluntarily subscribing to LTC insurance. The first, on the supply side, are related to the unattractive offer providing only partial coverage at a relatively high price. The second concern the characteristics of the demand for long-term care insurance and the manner in which individuals perceive the dependency risk.

Relying on individual responsibility to anticipate and cover out-of-pocket payments generated by the consumption of long-term care would be unadvisable given the characteristics of dependency risk and the demand for insurance. A more precise empirical analysis of individuals' perception of old-age dependency risk and insurance behaviours within the French context will provide a clearer view of the possibilities of introducing compulsory LTC insurance and under what terms and conditions.

In the general context of population ageing and increasing care needs, the management and financing of long-term care for elderly dependent individuals has been a key issue on the French political agenda for several years. If the Personalised Autonomy Benefit* currently counts almost 1.2 million beneficiaries, they are expected to have increased by 35% in 2030 and by a 100% in 2060 (Charpin and Tlili, 2011).

Of the three traditionally identified producers or financers of long-term care (the family, the State and the market), the family appears to be the cornerstone of the care system. According to the Health and Disability survey (DREES, INSEE) in 2008, 4.3 million individuals regularly provided informal home care to a family

* See definition in box page 2.

member aged 60 and over. In numbers of hours, family involvement amounts to triple that supplied by professional carers (Soulier and Weber, 2011). As illustrated by cost evaluations for informal care, this domestic production mobilises considerable resources, often under-estimated as difficult to observe and quantify[1]. Family structure is also subject to significant socio-demographic changes which necessarily questions the ability of private solidarity to meet the increasing care needs generated by an ageing population (Fontaine, 2011).

Evaluated at 24 billion euros in 2010, (1.4% of French GDP), public financing in favour of elderly dependent persons represents between 68% and 77% of the overall financial cost of caring for elderly dependent adults (Fragonard, 2011).

At national level, this amounts to an estimated deficit of 10 billion euros[2]. Certain private expenditures are not taken into account in this complex accounting exercise, more particularly costs relating to home adjustments. Knowledge of the real financial expenses borne by the individuals concerned is currently fairly poor due to the paucity of statistical data at individual level. We know that the amounts involved can be high: APA related out-of-pocket expenses for an individual assessed as GIR 1 living at home can potentially amount to 800 euros per month. According to the DREES, average out-of-pocket expenses borne by institutionalised individuals are estimated at 1,468 euros per month (Fragonard, 2011). In the case of individuals with Alzheimer's disease, average monthly out-of-pocket expenses are estimated at 570 euros for an individual living at home, and 2,300 euros in an institution (France Alzheimer Association, 2010). Even if different reforms to the APA scheme have been evoked to reduce these expenditures, it appears difficult to envisage extending government funded social aid given the current constraints weighing on government spending.

In this context, the LTC insurance market can be brought to play an important complementary role. Subscribing to an LTC insurance policy would offer individuals the possibility of covering themselves, even partially, against a financial risk that can amount to tens of thousands of euros[3].

Paradoxically, and despite the financial risk represented by old age dependency, the proportion of individuals subscribing to LTC insurance is limited. According to the French Federation of

Context

This synthesis of the literature initiates a research project that aims at comparing different social protection models envisaged in France to structure the care needs of elderly dependent persons. It more generally fits within the IRDES research programme broaching population ageing from several angles, notably the demand for LTC insurance and the notion of frailty in elderly persons.

1 Voir Davin et al., 2009 for a cost evaluation.

2 It should be noted that this evaluation does not take non-monetary private costs associated with informal care into account. Davin et al. (2009) for example, evaluate the cost of informal care at 6 billion euros per year

3 For example, monthly out-of-pocket expenses amounting to 1,468 euros in an institution amounts to a global private cost of almost 70,000 euros over a four year period ; that is to say the average period of time in which an individual benefits from APA.

Definitions

The Personal Autonomy Allowance (APA)

The Personal Autonomy Allowance (APA) is a benefits in kind scheme introduced in 2002. It is addressed to individuals with diminishing autonomy aged 60 and over, either living at home or institutionalised. It allows beneficiaries to finance the necessary help in performing activities of daily life. To benefit from this aid, individuals have to justify a certain loss of autonomy. The level of dependency is assessed according to the AGGIR scale (Gerontological Autonomy Iso-resource Groups) that classes individuals according to six levels of autonomy loss from GIR 1 to GIR 6. Only the first four levels, the most dependent, are eligible for APA benefits.

GIR 1 corresponds to elderly persons whose loss of physical and mental autonomy requires the permanent presence of carers. **GIR 2** concerns on the one hand elderly persons whose mental functions are not totally impaired but are unable to walk (confined to their beds or armchairs) and need help for the majority of daily activities; and on the other hand, elderly persons with partial loss of locomotive autonomy and impaired mental functions but need daily help in terms of body autonomy. **GIR 3** corresponds to persons with mental autonomy and partial locomotive autonomy but require daily assistance to maintain body autonomy. **GIR 4** concerns on the one hand persons unable to get out of bed unassisted, but once up can move around inside the home (certain need help with washing and dressing); on the other hand, persons able to move around but need assistance for bodily activities and meals.

The APA allowance for persons living at home amounts to the cost of the care programme established for the beneficiary (precisely identifying the help necessary to maintain an individual at home) eventually minus a co-payment calculated according to the beneficiary's resources.

(www.social-sante.gouv.fr)

Mutual insurance companies, provident societies and insurance companies

In France, the insurance market is made up of three main types of provider.

Mutual insurance companies are non-profit insurance companies governed by the Mutual Code and owned entirely by its policyholders. Promoting the values of solidarity, they do not impose selection criteria and are essentially financed by policyholders' premiums.

Provident societies are also non-profit organisations that do not impose selection criteria but are governed by the Social Security Code. They have a joint management structure founded on the equal representation of employers and employees.

Insurance companies, governed by the Insurance Code, are for-profit joint-stock companies. The premiums proposed can vary according to the risks presented by individuals (age, gender, health status…).

Antiselection and moral hazard

In certain markets, the different players will not all benefit from the same level of information, referred to as information asymmetry. This is frequent in the insurance market as all players do not share the same level of information concerning risks and policyholders' behaviour. This situation can result in adverse selection and moral hazard that can lead to market failures.

Antiselection (or adverse selection) is characterised by the fact that one party has private information signature of the contract: for example, if individuals with a high risk of becoming dependent insure themselves more than average but that the insurer is unaware of this, then the insurer is theoretically exposed to the risk of bankruptcy.

Moral hazard corresponds to a situation in which one of the parties cannot control the other's 'non-observable' decisions which can cause prejudice to the first party. A current example of moral hazard is that of health insurance since the insurer cannot totally control expenditures resulting from the patient/physician relationship.

Insurance Companies (FFSA), in 2010, 5.5 million individuals benefitted from LTC insurance coverage through an insurance company*, a mutual insurance company* (generally via additional coverage linked to a complementary health insurance policy) or a provident society*. Of these, fewer than 2 million individuals can be considered to have real long-term coverage as for the majority of beneficiaries it consists in annual insurance coverage at a fairly modest fee.

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French LTC insurance market in 2010

	Individuals insured		Total premiums collected		Total benefits delvered	
	Number in millions	in %	Amount in millions	in %	Amount in millions	in %
Insurance companies	1.6	29	403	77	150	89
Mutual insurance companies	3.6	65	97	18	18	11
Provident societies	0.3	6	25	5		
Total	**5.5**	**100**	**525**	**100**	**168**	**100**

Sources: FFSA and CTIP

Download the Excel© file on the IRDES web site.

Again according to the FFSA, the benefits paid out in 2010 to elderly dependent persons represented almost 166 million euros, a negligible amount given the aforementioned 10 billion euros in out-of pocket expenses[4]. This observation is not specific to France. Even in the United States where the LTC insurance market is the most highly developed, only 4% of expenses are financed by private insurance (Brown and Finkelstein, 2009).

This paradox questions the future role that could be played by the private insurance market in covering the dependency risk: would it be a viable option on which the public authorities could rely as a complement to public or family solidarity? Or, on the contrary, is the market limited to playing a minor role whenever LTC insurance is not compulsory?

This edition of Issues in Health Economics proposes a synthesis of the literature aimed at explaining the limited number of individuals willing to cover themselves against the financial risks associated with elderly dependency. Whether or not to introduce compulsory LTC insurance is a question frequently raised in different public reports, including a private sector pooling system (for example, Fragonard, 2011). Without wishing to predict its eventual public or private characteristics, an evaluation of the advantages and limitations of compulsory LTC insurance in terms of effectiveness and equity requires precise knowledge of decision-making behaviours regarding insurance coverage, and more generally, the manner in which risk is perceived within the population.

Other than the recent reports devoted to the public funding of elderly dependency, this synthesis is essentially based on the excellent review of the literature compiled by Assous and Mahieu (2002) and on more recent studies carried out on U.S data by Finkelstein, given the absence of studies based on French data.

Two reasons explaining individuals' reluctance to purchase LTC coverage are presented in turn: on the first hand, an unattractive offer providing partial coverage in the form of a monthly lump-sum cash benefit at a relatively high premium price and on the other, barriers on the demand side notably due to myopia and individual preferences which, given the characteristics of dependency risk do little to favour voluntary LTC insurance.

A relatively unattractive insurance offer?

Incomplete coverage in the form of a lump-sum cash benefit

In France, the different insurance products on the market covering long-term care expenses associated with elderly dependency all propose lump-sum cash benefits. In opting for benefits that are not indexed to the real cost of care consumption, insurers transfer part of the long-term uncertainties concerning the possibility of becoming dependent and the cost of long-term care onto the insured (Assous and Mahieu, 2002). Contrary to coverage based on the reimbursement of documented expenses (such as health insurance), there is no guarantee that the lump-sum benefit will cover the real cost of care. This is especially true because, for individuals subscribing to LTC insurance at the age of 60, potential long-term care needs are situated twenty or thirty years in the future, without any form of certainty regarding the future cost of care.

The offer nevertheless distinguishes itself by the length of its coverage. A first family of products offers annual renewable term coverage. The coverage guaranteed by mutual insurance companies falls into this category and concerns two thirds of individuals covered by LTC insurance (Table 1). In this case, LTC insurance is almost always linked to a complementary health insurance contract (Vasselle, 2011). The insurance only covers the current year and the policy contents can be revised each year by the insurer.

The level of coverage provided by these ancillary insurance products is thus somewhat relative, especially given that the lump-sum benefits for elderly dependency costs is relatively low. A large mutual insurance company, that alone insures almost 2 million individuals, integrated ancillary LTC coverage to its complementary health insurance in 2010. It guarantees a monthly lump-sum payment of 120 euros and only covers high dependency (GIR 1 or GIR 2). It confers an additional

[4] The insured population being relatively young, a significant proportion of the premiums paid still serve to fund future risks. According to the FFSA, at the end of 2010, almost 3.6 billion euros provision had been made for insurance companies, mutual insurance and provident societies' future commitments.

500 euros per year for dependent persons remaining at home and subsidises home care services up to a maximum benefit limit which is totally new in the French context.

A second family of products propose lifetime coverage guaranteeing benefits up to the insured party's death. Within this framework, almost 1.1 million individuals in France possess individual insurance from a private insurance company primarily covering elderly dependency risk. In exchange for a monthly premium, the insurer undertakes to pay a pre-specified lump-sum benefit[5] in the case of dependency until the death of the insured. According to the FFSA, the average monthly premium in 2011 amounted to 30 euros per month whereas the average lump-sum payment for dependent persons in the same year amounted to 583 euros per month. The monthly premium is nevertheless extremely variable from one contract to the next: it varies according to the lump-sum payment opted for in the contract (on average from between 340 to 1,942 euros per month) and the coverage level (high dependency only *versus* partial dependency). The monthly premium also increases considerably according to the individual's age at the time of subscription.

Insurance companies cover over half a million individuals having subscribed to LTC insurance either via a compulsory group contract or individual insurance where LTC coverage is ancillary and linked to another insurance contract (health, life insurance or savings). Ancillary coverage is somewhat limited relative to individual contracts with principal coverage: premiums associated with group contracts cost on average 7 euros per month for a monthly benefit of less than 200 euros. Provident Societies offer similar contracts to around 300,000 employees.

The insurance coverage proposed is thus incomplete. Two thirds of the contracts subscribed to through insurance companies solely cover high dependency, as is the case for the majority of contracts subscribed to through mutual insurance companies or provident societies[6]. To limit adverse selection effects, the vast majority of insurance contracts make provision for a waiting period in the case of illness. On signing the contract, the subscriber is thus only insured from the end of the waiting period, in general one year after signing with the exception of neurodegenerative diseases for which the waiting period increases to three years. There is no waiting period, however, for cases of dependency following an accident. Numerous contracts also have a three month no-claims waiting period.

Insurance companies furthermore limit the number of individuals that may potentially subscribe to LTC insurance by imposing a minimum age (between 18 and 50) and a maximum age (between 70 and 75 years old according to the insurer). To limit adverse selection, insurers also select potential subscribers by means of a medical questionnaire leading to refusal rates of between 15 and 20% (Dufour-Kippelen, 2008).

Expensive insurance coverage

To evaluate the attractiveness of private LTC insurance in terms of price, Brown and Finkelstein (2007) using American data, compared average premiums against expected benefits. Their estimations reveal that insurance companies place a relatively high pricing load on policies, close to 18%. In other words, in present discounted value, every euro paid in premiums will only pay back 0.82 euros in expected benefits. This average pricing load increases considerably from 18% to 51% if one takes into account the high number of individuals that break their contracts prior to risk occurrence, which means that premiums have been paid without the hope of benefitting from them. This pricing load appears excessively high when compared with the insurance market for other risks. As an example, the pricing load ranges between 15% and 25% for life insurance and between 6% and 10% for group health insurance contracts.

To our knowledge, there are no similar studies that would allow us to evaluate the price attractiveness of insurance contracts on the French market. It is, however, unlikely that they are more attractive in France than the United States. Different factors tend to drive up the price in France. First, the French market is relatively concentrated: the top four insurers share almost half the market (according to the Argus de l'assurance, 6th April 2012). Lifetime insurance coverage in France is furthermore essentially composed of individual insurance contracts for which transaction costs are traditionally higher than those incurred by group contracts.

The efficiency of the French market could also be affected by information asymmetry. From that point of view, the literature focuses on the existence of adverse selection* whereas moral hazard* can a priori be eliminated. In fact, it is fairly unlikely that individuals subscribing to LTC insurance will adopt behaviours susceptible to increase their risk of becoming dependent (ex-ante moral hazard). Similarly, the over-consumption of care and professional help induced by the fact of being covered (ex-post moral hazard) is not a threat in France since the benefits paid out are independent of actual care and services consumption. Empirical analyses carried out on American and French data have led to the conclusion that there is no adverse selection (Plisson, 2009; Cutler and Zeckhauser, 1997; Finkelstein and MacGarry, 2006)[7]. Finkelstein *et al.* (2005), on the contrary highlight the existence of dynamic adverse selection: individuals prematurely break their insurance contracts and as they are no longer insured, appear less exposed to the risk of dependency.

Insurers are more particularly confronted with the major specificity

[5] In addition to a monthly lump sum benefit, contracts generally provide for complementary benefits in the form of a cash payment for home adjustments or care assistance.

[6] Impairment assessment to evaluate the level of dependency satisfying the conditions of entitlement varies from one insurer to the next and the assessment criteria are generally more restrictive than those giving entitlement to the APA.

of dependency risk; the fact that it is a long-term risk. Individuals subscribing to LTC insurance between the ages of 50 and 60 will not be effectively exposed until twenty or thirty years later. To price their products, insurers are thus obliged to make a certain number of assumptions concerning the future probability of old-age dependency whereas it remains very difficult to predict disability-free life expectancy in future generations. This long-term uncertainty is reinforced by the fact that the market is relatively recent which considerably reduces the data available to insurers to construct their incidence tables. As pointed out by Cutler (1996), insurers expose themselves to an aggregate risk in terms of the population insured and as a result, possible excesses in the average premium price per insured. This uncertainty exposes insurers to the risk of bankruptcy as risk pooling between the insured cannot reduce the level of uncertainty. In this context, insurers are incited to cover eventual losses by over-funding which naturally leads to price increases.

However, the unattractiveness of French insurance contracts, which it would be worthwhile to confirm by a similar analysis to that conducted by Brown and Finkelstein (2008) on U.S data, is not the sole factor explaining the low take-up of LTC insurance. Simulations on U.S data carried out by Brown and Finkelstein (2008) show that even if private insurers hypothetically supplied lifetime coverage at an actuarially neutral price, the majority of individuals would still refrain from subscribing. Supply side imperfections are therefore not the only explanation for the low take-up rate and it is necessary to also look for explanations on the demand side.

Barriers on the side of individual preferences

On the demand side, two factors can explain individuals' low propensity to purchase LTC insurance. The first relates to the micro-economic concept of limited consumer rationality: individuals make their insurance decision in ignorance of both the insurance offer and their exposure to the risk of elderly dependency. A second explanation, without questioning individuals' rationality, highlights the specificities of dependency risk and in view of individual preferences, the way in which they create a barrier to voluntarily purchasing insurance coverage.

Low demand explained by a lack of information?

A rational individual should theoretically have a higher propensity to purchase insurance the lower the pricing load, all other things being equal; in other words when the aggregate cost of insurance is relatively close to the expected benefits. Yet, because of the differences in life expectancy (with or without disability) between men and women, the pricing load on the United States market is relatively unfavourable for men. The latter pay the same premiums as women but the expected benefits are lower. In the United States, for example, the average pricing load for men is between 25% and 50% higher than for women. All other things being equal, women have a greater incentive to subscribe to long-term care insurance. However, econometric estimations on U.S data fail to reveal significant differences between men and women regarding the demand for insurance. This result would suggest that the load factor has little impact on the demand for insurance which appears difficult to justify other than by the consumers' lack of information.

To account for the low take-up of private LTC insurance, the literature underlines the limited consumer rationality of individuals who make their insurance decision in ignorance of the financial risks to which they would be exposed should they become dependent.

Other than the lack of information on existing insurance products, the literature evokes myopia as a dominant trait among individuals resulting from lack of knowledge concerning the risk of elderly dependency; in other words an underestimation of the probability of being dependent at some point in the future (Bien *et al.*, 2012), and also an underestimation of the cost of long-term care for elderly dependent persons. Some individuals tend to overestimate the public provision of long-term care (Assous and Mahieu, 2002) or believe they are covered by their complementary health insurance or life insurance. In 2001, 34% of French employees believed they were covered against the risk of elderly dependency whereas only 5% were actually covered (Villatte, 2003). Finally, this myopia would explain individuals' uncertainty regarding expected reforms in the public provision of care and the increase in future care costs.

A certain form of denial[8] could also play an important role in the way in which individuals perceive the risk of elderly dependency. Denial does not signify inadequate information or poor knowledge of the risks involved but rather the deliberate refusal to take an identified risk into account. This irrational mechanism of risk negation could explain an individual's difficulty in envisaging an uncertain situation, the refusal to identify with an ageing person with reduced autonomy but also the financial inability to protect oneself from the risk.

Individual preferences that do not favour voluntary coverage

Other than the limited consumer rationality hypothesis, other explanations can also intervene. As underlined by Pauly (1990), or more recently by Bien *et al.* (2012), one can understand individuals' reluctance to subscribe to LTC insurance using a standard microeconomic framework in which individuals are considered both rational (adequa-

7 Finkelstein and MacGarry (2006) nevertheless show that the overall absence of adverse selection in fact hides other mechanisms of selection that work in the opposite direction. Two categories of individuals take subscribe to insurance more than others: individuals who perceive themselves more at risk and those characterised by a strong aversion to risk (who re statistically, on average, less at risk than the others).

8 The concept of denial is borrowed from the psychological literature and more precisely from studies on individuals' behaviour in the face of threatening situations or those beyond their financial resources (Cf. for example Paulhan, 1992).

tely informed amongst other things) and adverse to risk. The dependency risk also presents at least three significant characteristics that could lead an individual not to take out insurance.

High time preference lessens the effect of risk aversion

First characteristic: the temporal distance between the decision to subscribe to LTC insurance and the risk occurring. In this case, high time preference coupled with low risk aversion predominates.

In an uncertain situation, individuals distinguish themselves in their attitude towards risk. An individual adverse to risk will seek to reduce the income gap between different random situations that the future may or may not reserve (in this case between the state of dependency and non-dependency). The aversion to risk, a determinant factor in the understanding of insurance behaviour, is nevertheless inhibited in this particular case by the distant timeframe in which the risk may occur. If an individual purchases LTC insurance at the age of fifty, the probability of becoming dependent will be at its highest at around 80 years old. If individuals are not willing to transfer wealth to their end of life period, they are no more likely to insure themselves against a risk most likely to occur at the end of their lives. Time preference thus plays a major role in the decision to purchase insurance. Even individuals' highly adverse to risk could a priori only perceive a limited interest in purchasing insurance against a risk that may or may not occur twenty or thirty years in the future.

Moreover, as evoked previously, an LTC insurance contract involves a long-term commitment, especially when subscribed to before the age of 60. Paradoxically, risk aversion can be a barrier to subscription if an individual is financially uncertain of being able to continue paying the insurance premiums and fears paying for a product without hoping to reap the benefits.

The utility function in the state of old-age dependency

As with other health-related risks, being dependent has an impact on the manner in which individuals perceive their wealth. The literature evokes the hypothesis according to which individuals' place less value on their wealth in a state of dependency[9]. If an individual places more value on wealth in a state of 'non-dependency' there will be no interest in transferring wealth from the 'non-dependant' state to the 'dependent' state (Assous and Mahieu, 2002; Bien *et al.*, 2012). In other words, individuals are not inclined to transfer wealth to the elderly dependent person they may become in the future.

Family altruism

The third characteristic specific to the dependency risk: the important role played by informal carers.

The existence of LTC insurance implicitly supplied by family members could be a disincentive to purchasing insurance. Informal care provided by the family can in effect reduce the financial risk to which an individual may be subject. Individuals will thus be less inclined to purchase LTC insurance if important informal-care resources are available, and even less so if their preference is to be cared for by a family member rather than a professional. The literature evokes strategic behaviours on the part of parents who decide not to purchase insurance to maintain their children's incentive to care for them in the vent of dependency (intergenerational moral hazard theory, see Zweifel and Strüwe, 1998). The only currently known estimations based on French data, however, fail to validate this theory (Courbage and Roudaut, 2008).

On the contrary, individuals who know they can count on help from their families may also be incited to subscribe to LTC insurance to 'relieve' the family from care. This type of behaviour pertains to the presence of family altruism which would act as an incentive to purchase LTC insurance. From a theoretical point of view, family altruism signifies that an individual values the well-being of other family members and takes this into account when making individual choices. This form of altruism can intervene at two different levels (Pauly, 1990; Sloan et Norton, 1997). On the one hand, an individual may wish not to be a burden on the family (spouse and/or children) in the case of dependency. If informal care constitutes a cheap alternative to professional care, it can nevertheless incur indirect costs for informal carers[10], in general non-monetary costs. This would provide an incentive to the most altruistic individuals to purchase insurance in order to cover the family against the risks incurred by informal care provision. On the other hand, family altruism can also translate the desire to maintain one's standard of living and the family patrimony, notably in terms of inheritance. Purchasing insurance against the risk of elderly dependency can then be considered as a means of hedging against potential costs that would considerably reduce the value of family's inheritance.

Towards compulsory insurance coverage?

Given the numerous barriers to voluntary subscription to LTC insurance outlined in the literature, the market's capacity to supplement public and family solidarity appears fairly limited. If certain barriers may be lifted in the future, such as the unattractive product on the supply-side due to an immature market, it is far more difficult to lift obstacles on the demand side. In this context, the introduction of compulsory insurance coverage, whether public or private, would be the most effective way of pooling risks. In this respect, individuals' myopia or high time preference are arguments frequently put forward to justify the introduction of

[9] More formally, this hypothesis results in a positive cross-marginal utility between income and health (or dependency).

[10] Par exemple, la littérature sur les effets de l'aide informelle sur l'état de santé des aidants (comme Coe et Van Houtven, 2009) ou encore sur le renoncement partiel ou total au marché du travail (comme Bolin *et al.*, 2008).

compulsory LTC insurance. In the case of dependency risk, subscribing to LTC insurance includes important positive externalities regarding the well-being of informal carers, which would justify the introduction of compulsory insurance coverage.

If economic theory is able to explain the low take-up of LTC insurance, few empirical studies (outside the American context) have provided the means of testing and evaluating the relative weight of the different explanatory factors. Knowledge on the perception of dependency risk and the demand for insurance essentially comes from analyses carried out on U.S data. Yet, there are considerable differences between the French and American contexts. In the United States, LTC insurance is based on the partial reimbursement of healthcare costs whereas in France it consists in lump sum cash benefits. More especially, the U.S Medicaid programme which acts as a payer of last resort, has a considerable crowding-out effect on the demand for insurance (Brown and Finkelstein, 2008). This constitutes a major difference with France where the social benefits allocated via the APA scheme does not depend on the lump sum benefits paid out by LTC insurance.

The 2012 wave of the Health, Healthcare and Insurance survey (ESPS) conducted by IRDES and the Preferences and Patrimony in the face of Dependency Risk survey (PATED) conducted by the Médéric Alzheimer Foundation in 2011-2012, the results of which are currently being processed, will both provide more precise knowledge regarding the French context and will enrich on-going debates on the organisation and financing of long-term care for the elderly dependent. ♦

Pour en savoir plus

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10, rue Vauvenargues 75018 Paris •
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