Making health care more affordable and accessible for the elderly in the US and in France

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Credit: AI-generated image (disclaimer)

A significant number of Organization for Economic Cooperation and Development (OECD) countries have recently experienced a steep increase in the percentage of older residents due to the baby-boom wave hitting the 65-year-old barrier. In the United States and in France, the

vulnerable population aged 65 and over will increase due to population aging, growing prevalence of long-term conditions and effects of COVID-19 on health.

Despite the immense differences between the two countries' health care systems, the establishment in 1966 of the Medicare program for those 65 years and older moved the US health insurance level closer to that of France and other countries with universal health care.

However, as the costs of health and long-term care (LTC) have continued to rise in both countries, the direct costs for those covered—what remains to be paid after reimbursement by public and private health plans—have also risen. Moreover, stubborn inequalities in access to care remain, depending on the US state or the department in France. Reducing direct payments for the vulnerable, elderly residents thus constitutes a common policy challenge for the United States and France.

Common challenges

In 2018, residents 65 years and older made up 20% of the population in France and 16% in the United States. By 2060, it is projected to reach 23% in the US and 27% in France. As that proportion rises, so will the demand for care and long-term care. In 2018, the share of the gross domestic product (GDP) dedicated to government health care spending reaches 14.3% in the United States and 9.3% in France. The proportion of GDP devoted to public spending on long-term care remains relatively low, 0.5% in the US and 1.9% in France.

The high price of innovative drugs is a concern for all developed countries. In the last two years, the first cellular and gene therapies were approved in the United States and Europe. These medications are costly and concern only a small number of people, making cost-sharing

difficult. A significant increase in the number of products/indications from gene and cellular therapies is expected in the coming years along with new challenges in terms of financial sustainability and access to care for the most vulnerable.

Significant international differences have been shown for direct health care spending. In 2018, such payments represent 9% of the health spending in France, the lowest proportion in OECD countries, and 11% in the United States. Despite this low average level, access to health and long-term care for those 65 and over remains poorly coordinated and integrated, and is inefficient in both countries.

Long-term care affordability is a serious challenge in France

In France, a specific program ("Affections de longue durée") offers full, no-cost care at the point of service for chronic and costly diseases. It accounts for 70% of the health spending for statutory health-insurance payments. It represents 17% of the French population in 2017, while the population 65 and over represents 53% of all recipients. But this mechanism does not prevent high direct payments, due to the lack of annual capping.

This is even more the case for people over 60. The long-term care policy relies on a home-care scheme targeted at the elderly disabled, "Allocation personnalisée d'autonomie", which was shifted to local authorities (departments) in 2004, and on disability allowance, "Allocation aux adultes handicapés". While there are advantages to local management, it can also lead to inequalities in direct payment for a given health status and care needs. In all, the average monthly direct payment for home care represented 300 euros in 2011 (337 dollars).

… and care affordability is an immense problem in the US

The US health care system is characterized by problems of high direct payment and unequal spatial access to health and long-term care. In 2018, 94.1% of adults 65 and over were covered by a public plan. Medicare covers 57.8 million people, namely 17.8% of the population compared to 15.6% in 2013. Total Medicare expenditures represent 741 billion dollars in 2018. Two thirds of older Medicare recipients use long-term care or report they experience difficulties in performing daily activities. Long-term care comes out of the Medicaid program, and the eligibility requirements, services and cost-sharing policies vary state by state.

To reduce the burden of drug expenditures, Medicare Part D was introduced in 2006. The program has decreased elderly mortality by 2.2% annually, which in turn has been estimated to provide welfare benefits from lives saved of between 1.5 and 4.8 billion dollars. Part D has also resulted in a 15% decline in depressive symptoms. It has cut in-patient admissions and increased prescription-drug use through a reduction in out-of-pocket payments (OOPs).

Despite the benefits provided by the Medicare program, in 2017 23% of Americans 65 and older had to forgo care because of cost – nearly five times the rate in France, just 5%. The difference is a direct consequence of the cost of care in the United States. For instance, treatment for cardiovascular disease can require a direct payment of 317 dollars per year. For diabetes, the figure is 237 dollars, and for hypertension, 150 dollars. This in turn has an impact on Americans' financial health: A 2016 Kaiser Family Foundation study found that medical bills were a key factor in at least 1 million personal bankruptcies in 2015, and estimated that 52 million US residents had difficulty paying medical

bills.

Due to the growth in the number of people 65 and older and the appeal of Medicare Part D option, it is estimated that the program's costs will rise 7.3% over the next five years. The out-of-pocket costs for health and long-term care for the elderly are not only rising, but there are also high regional inequalities for long-term care—in particular, enforcement of the expansion of the Medicaid eligibility mandated under the Affordable Care Act varies greatly from state to state.

Understanding vunerability

The definition of vulnerability in health is neither universal nor absolute. Nevertheless, it lays down the rules for financial responsibility. Vulnerability can rely on an objective definition such as a medical approach (France's chronic-disease scheme). The recognition of vulnerability can also be defined by reaching a key age—65 for Medicare recipients in the United States, 60 for the home-care program in France.

Vulnerability can also refer to individual financial ability, measured either in absolute terms (means testing for Medicaid in the United States or the "Complémentaire santé solidaire" in France) or in relative terms (such as the capping of direct payments). The latter system exists in several countries, notably in Germany, Belgium and Switzerland, and to a certain degree in France and the United States. In France, the capping of annual direct payment was discussed in 2007 but not implemented. A recent French report calls for a direct payment cap, which would reduce out-of-pocket costs and improve care for dependent elderly residents.

In the United States, the weak limits on drugs prices and the absence of capping in Medicare Part D could further deteriorate access to care. Prescription drug costs are a significant problem given that 55% of older

Americans take four or more prescribed drugs, versus 22% for the French. Among other factors, this difference is driven by high rates of medical conditions such as obesity, dementia, respiratory illnesses and rheumatoid arthritis, an overprescription of antipsychotics, and relatively fast access to new treatments.

A set of managed care plans foster Medicare-Medicaid integration for those who qualify for both, known as "dual eligibles". About 20% of those eligible for Medicare also qualify for Medicaid, approximately 12.1 million individuals. This is innovative, as those who qualify for both will typically have no out-of-pocket health-care costs.

Political hurdles

Widening Americans' access to affordable health care has long been a subject of political debate, and one proposal is the public health insurance option proposed by the former vice-president and current presidential candidate Joe Biden. Among the provisions, it would use the wider coverage to negotiate lower prices with drug corporations to reduce the overall cost of care as well as lower patients' out-of-pocket costs. The White House website indicates that if re-elected, President Donald Trump would continue to seek to repeal the Affordable Care Act, but gives no specifics on what it would be replaced with.

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