



The Social Security System

Executive summary

This document is an executive summary intended to make the Report of the Court easier to read and comment on. Only the wording of the report itself has legal force.

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“Each year, the Cour des Comptes (French Court of Audit) shall draw up a report on the implementation of the social security financing acts. This report shall also present an analysis of all the accounts of the social security organisations subject to audit by it and shall draw up a synthesis of the reports and opinions issued by the audit institutions under its supervision. Said report shall be delivered to Parliament as soon as it is drawn up by the Cour des Comptes.” (Article LO 132-3 of the Financial Courts Code.)

The present report meets this legal obligation: it is the fifth such report to be drawn up, although the Court had previously drawn up three reports on the social security system with similar objectives, on the basis of the act of 25 July 1994.

The report is divided into four parts:

- Part 1 examines the accounts of the social security system for the year 2001 and the implementation of the 2001 Social Security Financing Act. It looks in turn at resources, expenditure, balances and the manner in which these are financed as well as the quality of the tools, in particular the accounting tools, used to draw up these accounts.*
- Part 2 discusses a major topic, which this year is the management of hospital expenditure. The main findings are based on hospital audits conducted by the Chambres régionales des comptes (regional audit chambers) and on regional hospital agencies (RHAs) audits carried out by the Cour des Comptes. It makes an initial assessment of the regulatory mechanisms governing the supply of hospital care (planning, resources allocation, reorganisation instruments) and their effects on changes in supply in relation to health requirements and to financial constraints. The study of accident and emergency units, of alternatives to hospitalisation and of drugs procurement by hospitals gives an insight into a number of linkages with general-practice medicine. One section deals with the armed forces health service, whose integration into public hospital-care supply is taking place in the context of the “professionalisation” of the armed forces.*
- Part 3 is, as in previous years, dedicated to risk management and to the administration of the social security bodies. It contains an initial assessment of the functioning of health agencies, most of which were recently audited by the Court, a report on the current situation in the health insurance system with regard to information system deployment, the regional and local policies for risk management and the various internal audit procedures in local agencies. In addition, subsidy payments by family benefit agencies to voluntary-sector organisations, as well as property asset management by social security organisations, which were examined by the regional audit committees for social security organisations accounts (CORECs), feature in this section.*
- Finally, Part 4 summarises the activity of the regional audit committees for social security organisation accounts (CORECs).*

The actions taken to follow up some of the recommendations issued by the Court are mentioned in the relevant sections.

As far as the financial statements are concerned, 2001 is paradoxical: although the surplus of the general scheme accounts was the largest recorded since 1990, their position remains insecure.

The general scheme accounts showed a surplus of €1.1 billion in 2001, after €0.7 billion in 2000, €0.5 billion in 1999 and – €1.4 billion in 1998. The improvement thus accelerated in 2001. As in 2000, the growth in revenue helped to strengthen the general scheme's financing capacity, with a 6.3% increase in the private-sector payroll.

However, accurate appreciation of the position of the financial statements is made even more delicate than usual by the fact that the accrual accounting accounts are not sufficiently reliable, as indicated by the high level of exceptional transactions recorded in 2001, whether they are related to revaluation of the receivables entered in the 1999 and 2000 accounts or to the provision corresponding to the State debt as a result of the FOREC (€2.2 billion). Moreover, in 2001, even more than in previous years, the substantial modifications to the rules for allocating revenue between branches, essentially linked to the methods chosen to finance the reduction in the hours of work, take some significance away from the branch balances and make the accounts less easy to interpret.

The improvement noted in 2001 is threatened both by the marked increase in expenditure, in particular on health insurance, interrupting a cycle of restraint starting in 1995, and by the weakening of the relevant regulatory mechanisms.

Over five years, from 1997 to 2001, the expenditure burden of the family benefits branch fell in

relation to the GDP, thus helping to meet the objectives of the three-year public finance programme. The growth in expenditure on pensions was moderate, because of the effect of the 1993 reforms and the moderate growth in the number of pensioners. But this trend, as everyone knows, will be sharply reversed over the next few years.

On the other hand, expenditure on health insurance rose by 5.6% in 2001, confirming the pessimistic analyses made by the Court in 2000 and 2001. The period was characterised by ever-greater contradiction between the ambition of the objectives that were set and the inability to implement regulatory mechanisms in the fields of general-practice medicine and of hospital expenditure. At best, it can be underlined that as far as the policy on medicinal products is concerned, although expenditure rose significantly in 2001, a start was made to re-examining the terms on which medicines are paid for. Moreover, significant action on prices should allow expenditure to be restrained in due course. Despite one or two structural measures that have not really started to bear fruit (doctor training, generic medicines, etc.), the tools for a realistic control of general-practice healthcare still need to be devised.

In any event, the growing disparity between the objectives set and the weakness of the means available to influence behaviours explains the high level of expenditure overruns and limits the significance of Parliament's vote on the Social Security Financing Act.

The report highlights three main findings on the management of hospital expenditure:

First, it underlines the ongoing difficulty experienced in introducing an efficient, shared information system and the extremely slow progress made in getting to know the way hospitals are organised and function. These are indicated by the lack of any major development of cost accounting, the over-limited use of Health information system data¹ and the restrictive design of the accreditation procedure implemented by ANAES.²

It should be possible to assess the quality of the service delivered by hospitals to users and to measure its cost to the community, as should be the case for any other public service. Studies of both these points need to be carried out rapidly with sufficient scope and transparency.

Second observation: the extent of restructuring is still modest. The Court found a multiplicity of tools for planning design and implementation but poor linkage between them. Regional health organisation schemes (SROs), health maps, permit schemes, hospital-care delivery plans, objectives and resources agreements and the different co-operation formulas must be made more consistent if they are to be the efficient

tools of a hospital restructuring policy. Moreover, it is striking that most hospitals have no care delivery plan. The preparation of third-generation regional health organisation schemes must be accompanied by a rationalisation and simplification of the system.

Changes in the number of beds per specialty and resources reallocation give the impression that the supply of care has been slightly restructured over the last few years. However, there is no reliable assessment of the effects of these rearrangements. There is a danger that restructuring will be dictated in future only by demographic considerations, in particular by the shortage of certain categories of medical or non-medical staff. Moreover, academic considerations weigh too heavily on hospital-care supply, whether it be in the distribution of doctors between specialties or between hospitals.

Third observation, relating to the RHAs. Their creation in 1997 has made it possible to gradually unify the controlling of the hospital system, covering both public and private hospitals, bringing the State and the health insurance system together in a flexible structure.

(1) Contained in the Programme de médicalisation des systèmes d'information, or PMSI.

(2) National Health Accreditation and Assessment Agency.



Presentation

The overall assessment of the RHAs' achievement is positive, but these new institutions have not been turned to as good an account as they might have been. They have indisputably enabled methods of work and the exercise of oversight to be modernised, particularly at the

budgetary level. But their actions come up against two limits: the insufficient decentralisation of some tools for regulating hospital expenditure and the persistent intervention of central government in resource allocation procedures.

Accounts

Key figures (in billions of €)

	2000	2001	%
GDP (value)	1416.9	1463.7	3.3
ONDAM ³ voted	100.4	105.9	5.3
ONDAM actual	103.0	108.7	5.6
Expenditure on SSFA ⁴ old age benefits	121.9	126.9	4.1
Expenditure on SSFA family benefits	40.3	41.8	3.7
Balance of general scheme	0.7	1.1	
General scheme health insurance deficit (in accrual accounting)	- 1.6	- 2.1	
Retirement pension reserve fund (accumulated balance)	3.2	7.0	

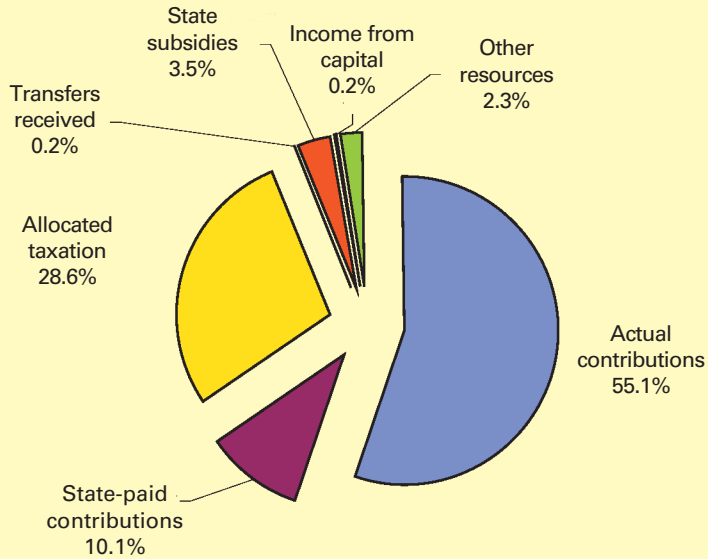
(3) National Health Insurance Expenditure Objective.

(4) Social Security Financing Act.

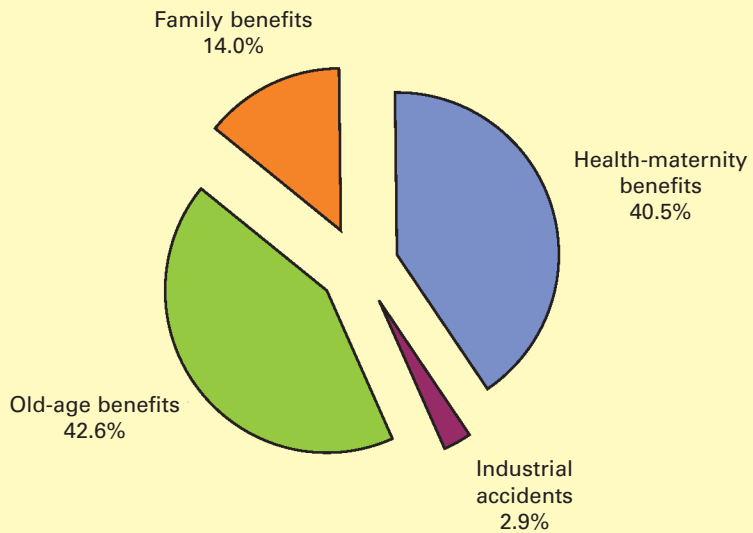
Expenditure covered by the SSFA (in receipts and expenditure) (in billions of €)

	Initial 2001 SSFA	Revised 2001 SSFA	Actual 2001 expenditure	Disparity with initial SSFA
Total expenditure	294.7	297.7	297.6	2.9
Including:				
– health & maternity	117.3	120.1	120.4	3.1
– industrial accidents	8.6	8.8	8.5	- 0.1
– old age benefits	126.6	126.7	126.9	0.3
– family benefits	42.2	42.1	41.8	- 0.4

**2001 revenue of basic schemes covered by the SSFA
(in receipts and expenditure) – Total: 302.7 billion of €**



**2001 expenditure of the basic schemes covered by the SSFA
(in receipts and expenditure) – Total: 297.6 billion of €**



Source : Social Security Directorate

2001 social security financial statements

→ *Main Findings*

→ The social security accounts continued to recover in 2001 and were in surplus for the fourth year running, with a positive balance of €1.1 billion, after €0.7 billion in 2000.

However, this recovery remains uncertain, for two reasons:

- it was essentially the result of the economic situation, in particular of the strong growth in the private-sector payroll (6.3% in 2001, for a 3.3% increase in GDP);
- social security expenditure increased considerably in 2001: + 5.6% for health benefits, + 4.1% for old-age benefits, + 3.7% for family benefits; there was an overall 4.6% increase in the expenditure covered by the SSFA, higher than that of the GDP.

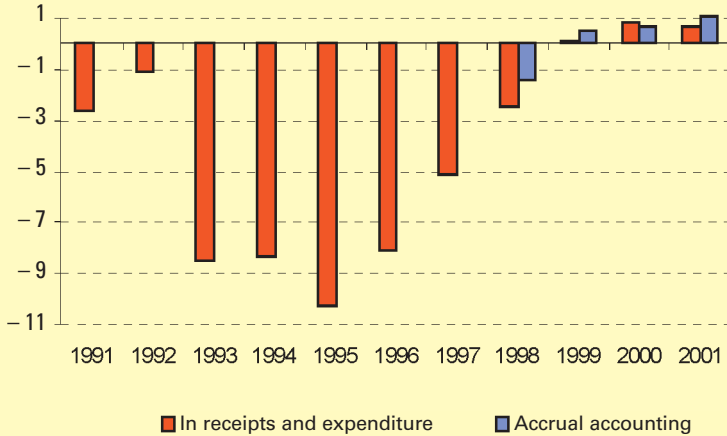
Between 1997 and 2001, there was a slight overall reduction in the proportion of the GDP devoted to social welfare expenditure, but it increased again in 2001 (20.3%, against 20.1% in 2000). The proportion of the national wealth devoted to compulsory social security contribu-

tions rose from 20.5% to 21.7%. Both results are in contradiction with the major objectives of the three-year public-finance programme: a fall in the proportion of the GDP devoted to public expenditure and to compulsory contributions.

→ The dynamic growth in health insurance expenditure once again led to an overrun of the ONDAM. This had been voted at €105.9 billion by Parliament, but actual expenditure came to €108.7 billion, i.e. an overrun of €2.8 billion. The ONDAM has systematically been exceeded each year since 1998 and the cumulated overrun over four years is close to €9 billion. The 2001 overrun was the highest ever. There is thus an ever-greater contradiction between the ambition of the objectives that were set and the inability to implement regulatory mechanisms. The short-term control systems failed to operate and the kind of medium-term regulation that might have an effect on behaviour has not yet been introduced.

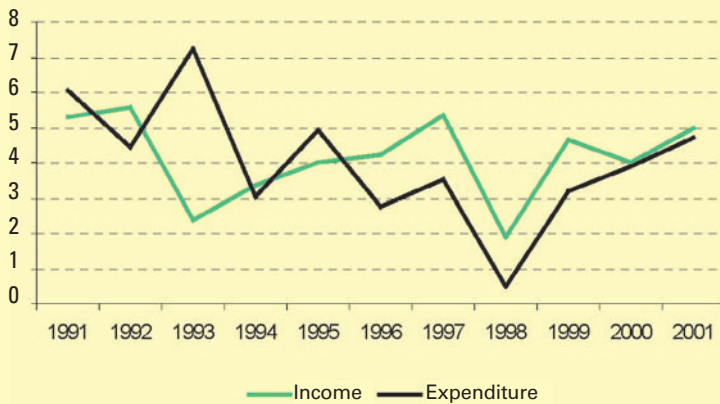
→ There was no significant improvement in the readability of the accounts in 2001.

Annual balance of the social security general scheme since 1990 (in billions of €)



Source : Social Security Accounts Commission.

Annual growth in the consolidated income and expenditure of the general scheme since 1991 (%)



Source : Social Security Accounts Commission.

Note: in 2001 the income of the general scheme grew by 5.0%, while expenditure grew by 4.7%.

The overall balance of the general scheme in terms of accrual accounting is in particular, as in previous years, the result of various accounting adjustments:

Adjustments of provisions and receivables (in billions of €)

	1998	1999	2000	2001
Accounting balance of the Social Security Accounts Commission	- 1.4	+ 0.5	+ 0.7	+ 1.1
Health insurance provisions (1999)		- 0.7	+ 0.7	
Receivables from 2000 contributions			+ 1.1	- 1.1
Receivables from 2001 contributions				- 0.3
CNAVTS ⁵ balance – agricultural workers			+ 0.2	- 0.2
FOREC debt			- 2.2	+ 2.2
Recalculated balance	- 1.4	- 0.2	+ 0.5	+ 1.7

Source : Social Security Accounts Commission.

The significance of the balances of the different branches was likewise distorted in 2001, given the many reclassifications of income and expenditure carried out between them, either to redeploy the surpluses of the family benefits branch to other branches (transfer to the CNAF⁶ of the cost of pension increases for having haised children, representing €3 billion

in the long run), or to direct additional resources to the FOREC from the FSV⁷ and the health benefit branch.

The Court once again emphasises the urgency of standardising accounting and the importance of stability in the financing rules of the different branches.

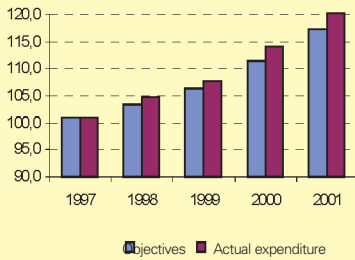
(5) National Old-Age Benefits Agency.

(6) National Family Benefits Agency.

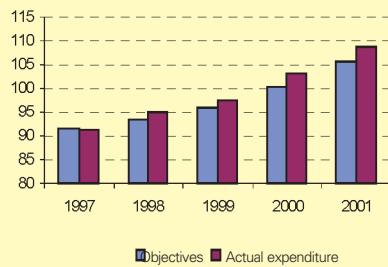
(7) Old-Age Solidarity Fund.

Social security expenditure covered by the SSFA Objectives and actual expenditure

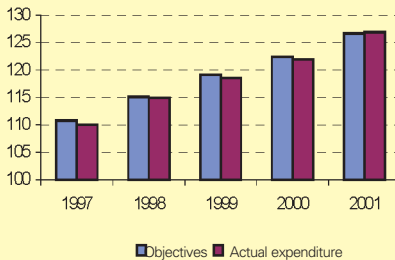
Health – maternity – invalidity
(in billions of €)



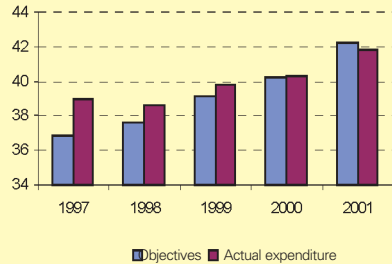
ONDAM
(in billions of €)



Old age – widowhood (*)
(in billions of €)



Family (**)
(in billions of €)



Source : for the three branches: Report of the Court + SSD. For the ONDAM, CCSS Report.

All objectives and actual expenditure are expressed in receipts and expenditure.

(*) All basic pension schemes having over 20,000 active or retired contributors with their own direct entitlements, i.e. other than compulsory supplementary schemes (notably AGIRC and ARRCO).

(**) The family benefits branch in the sense of the SSFA includes disability benefits and the AVPF.

Assessment base for social security contributions

→ Main Findings

→ Numerous mechanisms have been introduced that have the effect of removing income from the calculation base for social welfare contributions.

Assessed loss of receipts and extra tax expenditure associated with reductions in the calculation base (in billions of €)

	General scheme	State	Other social security schemes	Overall total
Business life	1,225	250	525	2,000
Profit-sharing, incentives, saving	3,104	1,076	1,200	5,380
Company insurance schemes	5,765	4,610	2,423	12,798
Total	10,094	5,936	4,148	20,178

Source : *Cour des comptes*.

→ There are three types of mechanism:

- those associated with business life: luncheon vouchers, holiday vouchers, compensation for business closure (dismissal, early retirement, retirement) ;

- those designed to encourage staff to save: profit-sharing, incentives and salary savings schemes ;

- those associated with company insurance schemes: essentially death and invalidity, in addition to the legally obligatory social security schemes.

→ These schemes are very varied in terms of both their techniques and their objectives. However, they share a number of characteristics. As they are basically optional and intro-

duced in businesses, they are by nature non-egalitarian, whether in terms of their distribution (proportion of the wage-earning population concerned), the scope of the cover that they offer, the status of their recipients (managerial or non-managerial staff) or of their cost (inequality in the size of the employer's contribution).

→ These mechanisms represent an increasing share of the remuneration for work. The extent of the exemptions granted explains their growth, with firms being likely to favour such mechanisms rather than paying a wage or salary, which is subject to social security contributions and taxation. Their development therefore represents a "threat" to the basic schemes.

→ Main Recommendations *

→ *Develop the evaluation of the effects of contributions exemption measures and assessment base reductions (n° 1).*

→ *A statement of the mechanisms affecting social security contributions and their cost should be published as an appendix to the Social Security Financing Act (n° 2).*

* A full list of the Court's recommendations can be found on pp. 26 *et seq.*

Hospitals

Key figures

→ Hospital expenditure covered by health insurance: €53.44 billion in 2000, i.e. 52% of the ONDAM.

→ Jobs in the private and public hospital sectors (in full-time job equivalents):

	Medical staff	Non-medical staff		Total
		Care	Other (1)	
Public sector	53,010	476,372	207,789	737,171
Private sector	72,313 (2)	149,034	70,012	291,359
Combined				1,028,530

Source : SAE, DHOS.

(1) Managerial staff, other administrative staff, support and social worker staff, medical technicians and technicians.

(2) Plus 29,102 independent practitioners on a part-time basis.

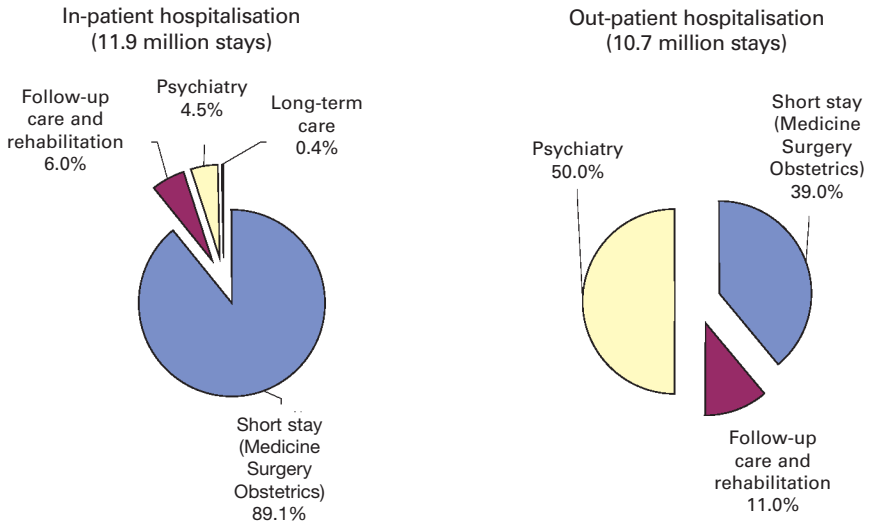
→ French hospitals as of 1 January 2000:

Category of hospitals	Number of hospitals in each category
Public hospitals	1,031
Private hospitals	2,024
<i>including:</i>	
<i>Not-for-profit hospitals covered by an overall budget</i>	660
<i>Regulated clinics (quantified national objective)</i>	1,314
<i>Hospitals funded through a day-price system</i>	50
Total	3,055

Source : SAE, DHOS.

In 2000, there were 22.6 million stays in hospitals, of which 11.9 million were in-patient and

10.7 million out-patient (i.e. of less than 24 hours' duration).



Source : DREES.

The record of Regional Hospital Agencies

→ **Main Findings**

→ The creation of the RHAs has made it possible:

- to have a single authority overseeing all hospitals, whether public or private;
- to reinforce collaboration between the State and the health insurance system at local level;
- to carry out a number of hospital restructuring operations to adapt the supply of care to the needs of the population.

→ Resources are allocated to hospitals less blindly:

- knowledge of hospital activity has advanced;
- the budgetary procedure has been improved and is slowly correcting the disparities between regions and between hospitals.

→ This dynamism has, however, recently run out of steam:

- the RHAs find it difficult to learn in detail about the functioning and the breakdown of costs of hospitals;
- central government has recently tended to encroach on the prerogatives of the RHAs. For instance, it directly allocates numerous ring-fenced credits to RHAs, which reduces their autonomy.

→ **Main Recommendations**

→ *The responsibilities assigned to local state services should be re-examined to allow them to concentrate on their core missions. Specialist skills should be developed in*

regional hospitals agencies with regard to management control, human resources management, organisation and hospital information systems (n° 15).

Accreditation

→ Main Findings

→ A statutory order taken in 1996 introduced a compulsory accreditation procedure for public and private hospitals. The system is run by ANAES (Agence nationale d'accréditation et d'évaluation en santé).

Procedures of this type exist in a number of neighbouring countries. In some cases they were introduced over 50 years ago.

The existence of independent procedures to assess the quality of care corresponds to strong expectations of the public, as shown by the success of publications on these topics (hospital league tables).

→ The procedure introduced was given the following characteristics that limit its scope:

- accreditation is compulsory and every hospital is necessarily accredited (with or without reservations);
- accreditation concerns the hospital as a whole and not a particular service;

- accreditation does not deal with the quality of clinical practices;

- accreditation has no connection with the planning, authorisation and resource allocation procedures that structure the supply of care.

→ Accreditation has been implemented slowly. The Agency took time to finalise the reference systems required (accreditation manual) and to recruit and train the visiting experts (the target of 650 visiting experts has still not been achieved). Once the reference systems had been established and the procedure defined, the Agency failed to implement them effectively. At the end of 2001, only 131 (out of over 3,000) hospitals had been accredited. The Agency does not appear to be in a position to conduct the 600 visits per year that would be necessary if accreditation is to be completed in a reasonable time.

Without strong impetus from government, there is a danger that accreditation will not be implemented with the required efficiency.

→ Main Recommendations

→ *Immediate thought needs to be given to methods of assessing the quality of care as part of accreditation (n° 23).*

→ *The Agency's internal procedures and the scheduling of visits need to be reviewed so that the accreditation procedure can be implemented more rapidly (n° 24).*

→ *A linkage needs to be defined between resource planning, allocation procedures and accreditation (n° 26).*

Hospital restructuring

→ **Main Findings**

→ Health maps and health organisation schemes are crude instruments, poorly inter-linked and poorly linked to other planning instruments (permits, hospital-care delivery plans, etc.), and are inadequate for identifying and facilitating the necessary restructuring. They do not contribute sufficiently to improving access to hospital.

→ The system of economic and financial information on hospitals is inadequate, despite recent progress in the use of the PMSI. The knowledge and the measurement of hospital costs are still obscure as a result of the unduly slow development of cost accounting in hospitals. Only a few studies show that hospital costs for the same pathology might very well be at least 30% higher in the public sector than in private clinics.

→ The multiplicity of legal instruments that can be used to implement planning and accompany restructuring masks the absence of systematic studies on the economic and financial impact of the operations carried out. Moreover, there is no exhaustive list of such instruments.

→ Overall, access to hospital appears to have shrunk slightly since 1994, if one measures it by the fall in the number of surplus beds (down from 47,700 to under 30,000). But this reduction is very slow and the indicator selected is of only limited significance as the reduction often hit beds that had been authorised but had never been set up.

→ The funds created to finance restructuring are failing to achieve their objective.

→ **Main Recommendations**

→ *The linkage between health maps, regional health organisation schemes, hospital-care delivery plans and objectives and resources agreements needs to be reviewed (n° 28).*

→ *The funds should be refocused to assisting in reorganisation (n° 29).*

Allocation of resources to hospitals by RHAs

→ **Main Findings**

- On the national level, a system has been introduced in order to progressively reduce the disparity of resources between regions.
- Within the framework of hospital “overall budgets”, RHAs have been obliged to progressively correct the disparities between hospitals in their region when drawing up hospital budgets.
- PMSI data are most often used to take better account of the activities of hospitals and to measure the cost discrepancies between them.
- The introduction of objectives and resources agreements has made it possible to go beyond the framework of the annual budget and to make the hospital strategy, as defined in

the care delivery plan, dovetail with the medium-term budgetary strategy.

But:

- The correction of inequalities is taking place slowly.
- Budgetary redeployment runs up against the inadequacy of restructuring.
- Hospital reporting to the RHAs remains inadequate.
- The interventions of central government often thwart the actions of the RHAs.
- There are different terms for the allocation of resources according to whether a public hospital (global allocation) or a private clinic (tariffs set within the framework of the OQN⁸) is concerned.

(8) *Quantified National Objectives.*

→ **Main Recommendations**

- *A system should be introduced to monitor and control hospital expenditure (n° 31).*
- *A final assessment of the previous budget implementation should be drawn up each year; the resource-allocation policy at national and regional levels should be appraised, in particular in order to measure the impact of the policies on the strategy of hospitals, in terms of internal management (particularly in relation to*

human resources) and with regard to the implementation of the regional health organisation schemes (reorientation of activities, co-operation or link-up with other establishments) (n° 33).

- *Budget decisions should be further decentralised to RHA level so as to consolidate regional policies (n° 34).*

Participation in hospital expenses by health insurance beneficiaries

→ **Main Findings**

→ The patient contribution fee and the hospital day charge have two objectives:

- to make beneficiaries aware of the cost of care and thus avoid abusive recourse to hospital, thus helping to control health insurance expenditure (via the patient contribution fee);

- to compensate for the “savings” in accommodation and food costs made by patients while they are in hospital (via the hospital day charge).

→ These objectives are no longer being achieved:

- the proliferation of exemptions reduces the effectiveness of these mechanisms: 85% of hospitalised patients are exempted from the patient contribution fee and around 50% do not have to pay the hospital day charge;

- payment of the patient contribution fee and the hospital day charge by mutual health insurance societies, social welfare or universal health insurance cover further reduces the impact of these mechanisms.

→ On the other hand, they create inequalities between categories of patients :

- the burden can be considerable for the minority of patients who have to bear the cost of the patient contribution fee and the hospital day charge;

- the rules regarding exemption can introduce discrepancies in the expenses covered, depending on the care received (for instance, in the Paris area hospitals,⁹ six days in hospital are billed at €64 for an appendectomy and €605 for medical care);

- there are also inequalities between different hospitals, either because of price differences in hospital day charges, which affect the patient contribution fee, or because of differences in the way the exemption rules are interpreted.

→ The great complexity of these mechanisms is reflected in high running costs. By way of illustration, the admission handbooks supplied to hospital staff usually contain over a hundred pages, half of which are solely concerned with patient contribution fee and hospital day charge issues.

(9) In the Assistance Publique-Hôpitaux de Paris network.

→ **Main Recommendations**

→ *The financial and social consequences of the patient contribution fee and the hospital day charge need to be measured exactly, together with the impact of the respective exemptions (n° 38).*

→ *On the basis of this evaluation, a reform of the current system needs to be prepared, to make it more equitable and to simplify it, without relinquishing every form of participation in hospital expenses by health insurance beneficiaries (n° 39).*

Hospital expenditure on medicines

→ **Main Findings**

→ Sales of medicines to hospitals has increased considerably: at €3.05 billion, they represented 16% of the 2001 turnover of the pharmaceutical industry in France, against only 12% ten years before. Three classes of medicines accounted for the major part of these increases: anti-inflammatories, anti-infectives and anti-cancer drugs.

→ This increase contributed to the growth of health insurance expenditure. Although ring-fenced funds were allocated to hospitals for expensive medicines, the increase still placed considerable strain on hospital budgets.

→ At local level, the powers available to hospitals to control their expenditure on medicines are limited:

- the purchasing procedures, based on competition between the laboratories, are largely inappropriate as molecules in a monopoly position represent 80% of hospital expenditure on medicines;

- research into the appropriate use of medicines has not yet been sufficiently developed.

→ At national level:

- knowledge of the market for medical products in hospital is virtually non-existent;

- the medical-economic appraisal of medicines is inadequate;

- the issue of temporary authorisations for use (ATUs) allows laboratories to gain access to the hospital market while imposing their own prices and without any adequate control of the medical service rendered.

→ The mechanism that limits the purchase of some medicines to hospitals and its corollary, the delivery of such medicines to out-patients, make it possible to circumvent the rules of access to the medical products market:

- in theory, medical products classified as “medicines delivered in hospital only” can be prescribed and delivered in hospital only;

- in practice, the delivery of such medical products to out-patients is growing rapidly. At present this represents about 30% of hospital drugs expenditure. This mechanism allows pharmaceutical companies to circumvent medical-products price-setting rules. The cost of these prescription drugs is then imposed on the health insurance system.

→ **Main Recommendations**

- *The information system on the consumption of medicines in hospital, which should be available to the public authorities, the health insurance scheme and hospitals, needs to be constructed: access to full, reliable databases, coding of hospital medicines, and regional observatories (n° 46).*
- *Buyer skills should be developed in hospitals and purchasing procedures appropriate to the particular characteristics of the hospital market recommended (performance-based calls for tender, negotiations in the case of genuine monopolies, bulk-buying organisations) (n° 48).*
- *Good-practice references and therapeutic protocols should be worked out and circulated, in particular for innovative and expensive products. Lists of therapeutic equivalents should be circulated (n° 49).*
- *ATUs should be issued by name and for free, as was traditionally the case. Cohort ATUs should be better controlled (n° 51).*
- *The categories of restricted prescription medicines should be reduced and medicines that can be delivered in hospital only should be strictly limited, as should the number of medicines concerned and the resultant delivery to out-patients (n° 52).*
- *The medical added value and the improvement of medical added value of all medicines, including those restricted to hospital use, should be assessed by the Transparency Commission (n° 53).*

Health agencies

Key figures

Eight agencies are in charge of health safety and monitoring:

- The Radioprotection and Nuclear Safety Institute (IRSN);
- The French Graft Agency (EFG);
- The National Health Accreditation and Assessment Agency (ANAES);
- The Health Surveillance Institute (InVS);
- The French Health Products Safety Agency (AFSSAPS);
- The French Food Safety Agency (AFSSA);
- The French Blood Agency (EFS);
- The French Environmental Safety Agency (AFSSE).

The report only deals with the first six of these agencies. The French Blood Agency will be treated separately. The French Environmental Safety Agency was set up too recently for it to be audited at this point.

Budget of the six agencies studied in the report (2001): €228.11 M.

Members of staff (2000): 2,202.

→ Main Findings

→ The health agencies, that have been created progressively since 1993, are in charge of the health safety and monitoring policy:

- The build-up of these agencies was slow;
- they were given new responsibilities, even though they did not yet have a proven track record in their initial fields of operation (e.g., for ANAES);

• there is some overlap between the responsibilities of the various health agencies.

→ The resources allocated to health agencies have been vastly increased: between 1998 and 2001, their budgets were raised by 56% and 629 new members of staff were recruited.

→ However, shortcomings in management have contributed to the slow pace of their build-up:

- Red tape and design faults in staff statutes meant that the recruitment of high-tech specialists lagged behind schedule.
- The management of IT projects was poor (in the cases of AFSSAPS, EFG, InVS).
- The whole of the money that had been allocated was not used up, partly because of recruitment problems and delays in IT projects.
- Unequal attention was given to the development of a coherent communications strategy.
 - The development of the health security and monitoring policy might be jeopardised if these management shortcomings are not addressed.

→ Main Recommendations

- *Health agencies need to reinforce their administrative skills in order to fulfil their responsibilities in a healthier legal and financial framework (n° 54).*
- *All the agencies need to work out their IT development plan and put the resultant computer applications in place as quickly as possible (n° 55).*
- *Contracting between the central departments in charge and the agencies, which some have undertaken within the framework of objectives and resources agreements, should be generalised (n° 56).*
- *The rules for allocating and monitoring subsidies are in urgent need of clarification (n° 57).*
- *The establishment of a common statutory framework for the agencies' contract workers who are "common-law employees" is currently being worked out and needs to be completed quickly (n° 58).*

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1. Develop the evaluation of the effects of contributions-exemption measures and assessment-base reductions.
2. A statement of the mechanisms affecting social security contributions and their cost should be published as an appendix to the Social Security Financing Act.
3. Clarify the statute with regard to liability for dependency insurance social security contributions and AGFF contributions.

NB. – Sections marked with a star (*) are not subject to any recommendations.

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For the elderly sector :

- 4. The new costs noted on signature of the care agreements should be analysed with a view to rescheduling the ONDAM for the elderly.
- 5. A document enabling the “elderly” sub-budget to be included within expenditure on care for the elderly should be created as an appendix to the SSFA.

For the disabilities sector :

- 6. A control structure should be set up to develop an appropriate budgetary information system.
- 7. A panel of care institutions should be created to ensure that costs are known and monitored.
- 8. The different plans need to be dovetailed with one another, identifying the source of the resources allocated to each.

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9. Accounting procedures for provisions and receivables should be improved so as to obtain accrual-accounting accounts that give an accurate picture, and all necessary steps-taken to ensure that the tools currently being worked out are effectively operational by the end of 2002.

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10. Payment of money owed by the State to finance employment measures and social security benefits should be improved through a more realistic appreciation of the value of progress payments. Greater use should be made of payment agreements between the State and its social security creditors.

11. All long-standing debts should be cleared, in particular the debt resulting from the mechanism for the gradual reduction of social security contributions on low salaries for companies in the textile/clothing/leather/footwear sector.

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12. The piece of secondary legislation appointing the members of the *Haut Conseil de la comptabilité des organismes de sécurité sociale* should be published quickly.

13. Accounting services should be provided with the necessary resources, particularly as regards staff.

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14. The respective responsibilities of the *préfets* and the RHAs should be clarified.
15. The responsibilities assigned to local state services should be re-examined to allow them to concentrate on their core missions. Specialist skills should be developed in regional hospital agencies with regard to management control, human resources management, organisation and hospital information systems.
16. Ensure that agencies have adequate resources for the tasks they perform by regularly assessing their operations (numbers, availability and skills of the staff of RHAs, functional organisation) and the impact of policies, reinforce inter-regional co-operation.
17. The ordinances necessary for the assessment results to be taken into account in the authorisation procedure need to be adopted.
18. The nomenclatures used in the different information systems should be standardised.
19. The quality of the new SAE should be assessed and the persisting divergences from the PMSI reduced.
20. Development of the PMSI outside the field of short-term hospital stays needs to be speeded up.
21. Expertise in general and cost accounting and hospital information systems should be developed in the RHAs; centres of responsibility need to be introduced in hospitals.
22. The necessary arrangements need to be made for the effective general implementation of cost accounting in hospitals.
23. Immediate thought needs to be given to methods of assessing the quality of care as part of accreditation.
24. The Agency's internal procedures and the scheduling of visits need to be reviewed so that the accreditation procedure can be implemented more rapidly.
25. The content of accreditation reports needs to be re-examined with a view to achieving greater standardisation and the positioning of the college of accreditation reviewed so that cases can be processed more quickly.
26. A linkage needs to be defined between resource planning, allocation procedures and accreditation.

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- I. – Implementation of hospital planning
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27. The drawing up of hospital-care delivery plans should be better monitored at national level and the reasons for non-approval analysed.

28. The linkage between health maps, regional health organisation schemes, care-delivery plans and objectives and resources agreements needs to be reviewed before third-generation regional health organisation schemes are launched.

29. Restructuring funds should be refocused towards hospital reorganisation.

30. The procedures for granting FIMHO¹⁰ assistance need to be improved in terms of faster decision-making and a choice of operations more consistent with hospital-care supply restructuring.

(10) Investment fund for hospital modernising.

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31. A system should be introduced to monitor and control hospital expenditure.

32. There should be better justification for the granting of exceptional payments to hospitals and better medical-economic appraisals of restructuring projects.

33. A final assessment of the previous budget implementation should be drawn up each year; the resource allocation policy at national and regional levels should be appraised, in particular in order to measure the impact of policies on the strategy of hospitals, in terms of internal management (particularly in relation to human resources) and with regard to the implementation of the regional health organisation schemes (reorientation of activities, co-operation or link-up with other hospitals).

34. Budget decisions should be further decentralised to RHA level so as to consolidate regional policies.

35. The budget allocation procedure should not extend over the entire year.

36. The mechanism for dividing up the overall grant between the different social security schemes should be simplified.

37. A detailed assessment should be made of the reform of terms of payment of expenses to private clinics by the health insurance agencies. It should be ensured that the objective of improving the statistics is achieved so that the SNIREP can be abandoned. Possible simplifications, further developments and extensions of the mechanism now in place should be examined.

38. The financial and social consequences of the patient contribution fee and the hospital day charge need to be measured exactly, together with the impact of their respective exemptions.

39. On the basis of this evaluation, a reform of the current system needs to be prepared, to make it more equitable and to simplify it, without relinquishing every form of participation in hospital expenses by health insurance beneficiaries.

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- I. – Alternatives to full hospitalisation
- II. – Handling of medical emergencies
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40. Ambulatory surgery as really practised in public hospitals should be brought into conformity with the standards laid down in the regulations.
41. Once the overall effect of its application by the RHAs has been assessed, thought needs to be given to adapting the procedure designed to neutralise the disincentive to the development of ambulatory surgery built into the Medical information system programme.
42. The measures taken for the promotion of home medical care should be implemented.
43. The effects of the numerous measures adopted over the last few years to upgrade accident and emergency departments need to be assessed, as do the causes of the remaining difficulties (in particular the disparities in expenses billed to patients).
44. Participation in emergency medical service response teams by doctors in private practice should be developed, by clarifying the terms of funding.
45. Current experiments in the handling of medical emergencies by general-practice structures in co-operation with hospitals need to be assessed.
46. The information system on the consumption of medicines in hospital, which should be available to public authorities, the health insurance scheme and hospitals, needs to be set up: access to full, reliable databases, coding of hospital medicines, and regional observatories.
47. Effective recourse to bulk-buying organisations should be authorised for the purchase of medicines by hospitals, possibly by adapting the Public Procurement Code.
48. Buyer skills should be developed in hospitals and purchasing procedures, appropriate to the particular characteristics of the hospital market, recommended (performance-based calls for tender, negotiations in the case of genuine monopolies, bulk-buying organisations).
49. Good-practice references and therapeutic protocols should be worked out and circulated, in particular for innovative and expensive products. Lists of therapeutic equivalents should be circulated.
50. The 1991 regulations on the prescribing and issuing of medicines to named recipients should be applied and the system computerised to make these activities completely safe.
51. ATUs should be issued by name and for free, as was traditionally the case. Cohort ATUs should be better controlled.
52. The categories of restricted prescription medicines should be reduced and medicines that can be delivered in hospital only should be strictly limited, as should the number of medicines concerned and the resultant delivery to out-patients.
53. The medical added value and the improvement of medical added value of all medicines, including those restricted to hospital use, should be assessed by the Transparency Commission.

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54. The health agencies need to reinforce their administrative skills in order to fulfil their responsibilities in a healthier legal and financial framework.

55. All the agencies need to work out their IT development plan and put the resultant computer applications in place as quickly as possible.

56. Contracting between the central departments in charge and the agencies, which some have undertaken within the framework of objectives and resources agreements, should be generalised.

57. The rules for allocating and monitoring subsidies are in urgent need of clarification.

58. The establishment of a common statutory framework for the agencies' contract workers who are "common-law employees" is currently being worked out and needs to be completed quickly.

SECTION XI

INTERNAL AUDITING AND RISK MANAGEMENT IN THE HEALTH INSURANCE SCHEME

- I. – Internal auditing in the primary health insurance agencies (CPAMs)
- II. – Regional and local health-risk management policies

59. Protocols and internal audit plans should be drawn up in all CPAMs and CGSSs.¹¹

60. Best practices and skills should be shared more widely between social security organisations.

61. The orientations of the internal audit steering committees, action plans and annual reports should be widely circulated within each organisation.

62. Risk-analysis and performance-measuring methods should be developed.

63. The risk-management framework should be simplified by giving effective powers over all medical services and agencies of a region to a single regional authority, so that a common risk-management policy covering hospitals and general-practice medicine can be implemented.

64. Impact assessments should be generalised and their methodology improved.

65. A balance needs to be kept between new forms of risk management, for which the regional level is more appropriate, and the more traditional forms of audit, particularly individual audits, which should constitute the basic audit activities of authorities operating at local level.

(11) *Local health insurance agencies.*

SECTION XII

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- I. – Property management by local general scheme and agricultural scheme agencies
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- III. – Current state of organisation of the SESAM Vitale system (*)

RECOMMENDATIONS

66. Active management of the areas occupied per member of staff should be ensured, particularly in case of staff reductions, and suppliers should be induced to compete with one another more systematically.

67. All agencies should be given access to real estate expertise, while ensuring that there is no duplication of resources between the UCANSS and the agencies.

68. When of only limited interest, the UIOSSs¹² of the general scheme and the SCIs of the agricultural scheme should be dissolved.

69. Clear directives should be established for agencies, so as to put an end to possible conflicts of interest and confusion of responsibilities between the agencies and subsidised charities.

70. Greater homogeneity in the behaviour of the agencies should be ensured in implementing the charity aid policy, particularly through effective observance of the rule that agreements should be used.

(12) *Social security organisations real-estate unions.*

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