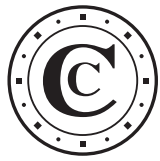
Cour des comptes



PUBLIC FINANCES AND ACCOUNTS

SOCIAL SECURITY

Report on the implementation of the Social Security Finance Acts

Executive summary

October 2021

NOTICE

The purpose of this document is to facilitate the reading of the Court of Accounts' report, which alone commits the Court. The responses of the administrations and agencies concerned are included in the Court's report.

The order of the summarised chapters corresponds to that of the report.

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Presentation

The consequences of the pandemic will have a lasting effect on the situation of government finances and in particular social finances. Close to break-even point in 2019, the basic social security schemes and the old-age solidarity fund (FSV) posted a deficit of an unprecedented magnitude (€39.7 billion) in 2020. According to the forecasts of the Social Security Finance Act for 2022, they will still see a very high deficit in 2021 (€34.8 billion in forecast deficit).

Beyond 2021, according to the stability programme sent to the European Commission in the spring, the Government's objective is to reduce, without tax increases, the public deficits resulting from the pandemic and to stabilise the public debt ratio, then to initiate its decrease by 2027. The Court notes, however, that the conditions for the recovery of social finances are yet to be defined. It feels it is necessary for this to be organised based on reforms to be initiated in the fields of pensions and health in particular.

This report, successively:

- conducts an in-depth analysis of the situation in the social security accounts and formulates recommendations concerning, firstly, possible ways to improve the content and methods of drafting social security finance acts and, secondly, the conditions enabling more effective control, over the long term, of changes in health insurance expenditure (part I);

- conducts the first appraisals of the management of social security during the pandemic by emphasising that, overall, although the responses to the crisis were useful, this was most often the case in exceptional conditions and according to exception rules that are now best fully avoided (part II);

- illustrates, through four examples, the need to relaunch management reform or modernisation projects, which had to be suspended or slowed down during the pandemic (part III).

1 Curb social security expenditure and indebtedness

Relative to GDP, France's public deficit was, in 2020, the sixth highest among the 19 eurozone countries, nearly two points of GDP higher than the average measured for these countries and five points of GDP higher than Germany's.

The pandemic, which has affected all countries to varying degrees of intensity, is not the only explanation for this situation. Before the onset of the crisis, France had less leeway than most of its European partners because of the levels of national deficit and debt. In 2019, the rate of compulsory levies in France reached 45.5% of GDP, the highest rate in the European Union, more than five points of GDP above the eurozone average (40.4%) and Germany (40.3%). French public expenditure was also the highest in the European Union, reaching 55.5 points of GDP, or 8.8 points of GDP above the average in EU countries (46.6 points).

Over 20 years, between 2000 and 2019, the increase in public expenditure's share of GDP (+4.5 points) can be attributed to changes in social expenditure: +2.8 points for pension expenditure and +1.7 points for public health expenditure. In the report submitted to the Prime Minister[1] on the public finance strategy in relation to the end of the pandemic, the Court stressed the need to consolidate government finances, in particular by moderating the increase in social expenditure. The first two areas in which it recommends action are old-age insurance, an aspect that is not examined further in this report, and health insurance, an issue that is covered in several chapters.

[1] Court of Accounts, "A government finance strategy for exiting the crisis", June 2021.

Curb social security expenditure and indebtedness

Following the fall in revenue that took place in 2020 and that has been partially offset since, the sharp increase since 2020 in health insurance expenditure linked directly and indirectly to the pandemic has caused a profound and significant imbalance in the social security accounts, an analysis of which is the subject of the first chapter of the report (chapter I).

To help better control the rise in social expenditure, improvements in the organisation and scope of social security finance acts could be useful (chapter II). A more rigorous interconnection between the objectives of controlling health insurance expenditure and actions aimed at better meeting the population's health needs through more relevant and quality care also appears essential (Chapter III).

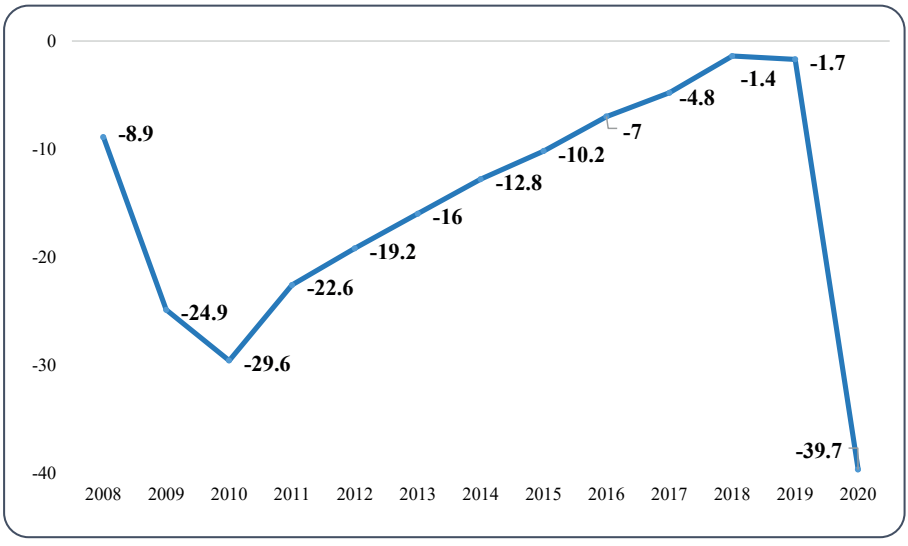
1 - The financial trajectory of social security from 2020: the challenge of the pandemic's consequences

The Covid-19 crisis has caused a long-term disruption in the financial trajectory of social security.

An unprecedented deterioration in the social security accounts in 2020

In 2020, the aggregate deficit of the mandatory basic social security schemes and the Old-Age Solidarity Fund (FSV) reached €39.7 billion, or 1.7% of GDP, including €38.7 billion for the general scheme and the FSV. This deficit exceeds that recorded in 2010 (1.5% of GDP), following the economic recession caused by the financial crisis of 2008-2009.

Change in the aggregate deficit of basic mandatory social security and FSV schemes (2008-2020, in €bn)



Source: accounts of the social security and FSV schemes

Curb social security expenditure and indebtedness

Compared to the forecast of the 2020 Social Security Finance Act (LFSS), the deficit of the general scheme and the FSV increased by €33.2 billion (by €36.8 billion compared to 2019). All of the social security branches recorded deficits, even the family and AT-MP branches, which were structurally in surplus. The healthcare branch recorded the largest deficit (€30.4 billion).

The increase in the deficit in 2020 is due to a combination of unfavourable developments affecting both revenue and expenditure.

Revenues from the general scheme and the FSV fell by €11.8 billion (-2.9%) compared to 2019 and €18.8 billion (-4.6%) compared to the forecast of the 2020 LFSS, due to:

- the decline in economic activity (-7.9%) and the fall in employment (-1.2%);
- the widespread use of short-time working subject to lower social security contributions (absence of employer contributions and the generalised social contribution rate of 6.2%, versus 9.2% for earned income), which involved an average of three million workers in 2020;
- the government decision to halve the base of professional income used to calculate social security contributions for self-employed workers in 2020, in order to ease their cash flow situation;
- the increase in provisions for the risk of the non-recovery of URSSAF (organisations for the payment of social security and family benefit contributions) debt commitments from businesses and self-employed workers, from €1.6 billion in 2019 to €7.5 billion in 2020.

Conversely, expenditure increased by €24.9 billion (+6.2%) compared to 2019, including €14.6 billion over the forecast recorded in the 2020 LFSS, mainly concerning the healthcare branch. The national healthcare expenditure target (ONDAM) was exceeded by nearly €14 billion, thereby increasing 9.5% compared to 2019, versus an expected increase of 2.45%.

This is because the pandemic has resulted in additional expenditure: purchases of masks and other personal protective equipment, screening tests, compensation for the additional operating costs of healthcare and medical-social agencies (including "Covid" premiums) and specific daily allowances. In addition, common law allowance expenditure has soared. Furthermore, the pay rise measures in healthcare and medical-social agencies provided for by the "Ségur de la santé" agreements caused €1.4 billion in additional expenditure in 2020.

A limited reduction in the deficit in 2021

The draft Social Security Finance Act for 2022 includes a slight reduction in the deficit of the general scheme and the FSV: in 2021, this would total €34.6 billion, including €30 billion for the healthcare branch.

The strong recovery in economic activity, employment and consumption is driving up revenue (+7.9%).

However, expenditure looks to be increasing almost as quickly. In 2021, the "Ségur de la santé" measures are ramping up (+€7.9 billion anticipated). In addition, the gross additional costs directly linked to the pandemic (€14.8 billion) are very much higher than the initial forecast (€4.3 billion). This is due in particular to vaccination-related expenditure (nearly €5 billion), as well as the cost of screening tests (over €6 billion).

Define a rebalancing path focused on controlled expenditure

At the end of 2021, the social debt borne by the social security debt repayment fund (CADES) and the central agency for social security funds (ACOSS) could reach €166 billion (or 6.8% of GDP). In two years, it will have increased by €51 billion compared to the end of 2019 (€115 billion).

Beyond 2021, the draft Social Security Finance Act for 2022 provides for a deficit in the general scheme and the FSV of around €22 billion in 2022 and €15 billion in 2023. From 2024, the deficit would no longer be reduced and would stagnate at around €13 billion.

Based on these forecasts, the cap of €92 billion for authorising the reversal of deficits by the CADES for the financial years 2020 to 2023, set by the law of 7 August 2020, will not cover the 2023 deficit.

There is a high risk that the deficit will permanently exceed €10 billion from 2024. The pandemic and its direct and indirect consequences have disrupted the financial situation in social security.

Firstly, definitive social revenue losses are inevitable due to the fall in economic activity in 2020 and despite the strong recovery observed since. Secondly, health insurance expenditure will be higher by around €30 billion compared to 2019, beyond the expenditure directly linked to the pandemic: the "Ségur de la santé" will generate €12.5 billion of additional spending in 2022, i.e. the equivalent of 0.5% of GDP, including nearly €10 billion in long-term pay rises. Other recent decisions concerning hospitals, health products and community medicine are contributing to an increase in health insurance expenditure.

Rebalancing the social security accounts is essential so that today's social benefits are no longer partly financed by borrowing, and therefore by future generations.

To this end, it is appropriate to allocate to the reduction of deficits – rather than to new expenditure – any additional revenue compared to forecasts. It is also important to initiate resolute actions to improve the efficiency of expenditure, particularly in the fields of health insurance and pensions, in order to significantly reduce their increase compared to current forecasts.

Appendix: opinion on the consistency of the balance schedules and of the schedule Opinion on the balance schedules and the social security asset schedule concerning the 2020 financial year.

Curb social security expenditure and indebtedness

Pursuant to the organic law on social security finance acts, the Court verified the consistency of the balance schedules and the asset schedule of all the schemes and agencies constituting social security, concerning the 2020 financial year, the last closed accounting year, before they are submitted for adoption by Parliament in the Social Security Finance Act for 2022.

The Court ensured that the information appearing in this combined (consolidated) social security income statement and balance sheet complied with the accounting data of the social agencies, that the reciprocal transactions between them were correctly eliminated and that information delivery to Parliament was high-quality.

The Court considers that, subject to certain observations concerning in particular the consequences of the opinions it issued in connection with the certification of the French general social security system financial statements[2], the schedules provide a coherent depiction, firstly, of income, expenditure and the balance (balance schedules) and, secondly, of the assets and liabilities (asset schedule) of the social security entities included in their respective scopes.

Recommendations

1. Review the procedures for establishing, validating and transmitting to the Court the balance schedules, the details of the restatements made from the accounts of entities included in their scope and the elements of the draft appendix 4 that pertain thereto, so that the Court is, in all cases, in a position to communicate to Parliament its opinions on their consistency within the timeframe resulting from the organic provisions, in force as anticipated, of the social security code (ministry for security social).

2. (reiterated recommendation) End the contractions of income and expenses in the balance schedules, which do not comply with the normative framework set by the organic law on social security finance acts, for the establishment of the accounts of the mandatory basic social security schemes (ministry for social security).

[2] Given their particular scope, the uncertainties affecting the 2020 accounts of the recovery activity did not allow the Court to express an opinion on them. With regard to the branches of services of the general scheme (excluding recovery activity), the Court made six additional reservations regarding their 2020 accounts (22 reservations, versus 16 for 2019). Firstly, these are linked to the findings concerning the accounts of the recovery activity. In general, the pre-existing reserves have been strengthened, see Court of Auditors, Certification of the French general social security system financial statements and the CPSTI, May 2021.

2 - Social security finance acts: a framework requiring reform

The Social Security Finance Acts (LFSS) were introduced in 1996. While the Parliament adopted at first reading a bill reforming the organic framework of the LFSS, the Court wished to make known its analyses on the changes that could be made to the LFSS to improve the management of social expenditure.

The LFSS: a keystone of the financial governance of social security

Every year, a draft LFSS prepared by the Government submits in the autumn for approval by Parliament the expenditure, income and balances recorded for the past year, the expenditure objectives, the income forecasts and balance forecasts for the coming year and updated objectives and forecasts for the current year.

Nevertheless, the LFSS could make a stronger contribution to the transparency of the choices concerning policies and social finances and to the restoration of the financial position of social security.

Information for Parliament needs to be expanded

The annual LFSS in the autumn performs the function of recording the results of the past year, which is now neglected. As the Court recommended, the current revision of the organic law on the LFSS includes the creation of a law approving the accounts of the past year in the spring, as is the case for central government, in order to more effectively assess, year by year, changes in the balance and performance of the social protection system.

However, the expected progress in the creation of laws approving the social security accounts depends in part on the provision to Parliament of more complete information.

In the laws approving the accounts, as in the annual LFSS, information on income and expenses would benefit from being provided in a more detailed manner, by type or by scheme.

In addition, the appendices to the draft social security finance acts should provide a better explanation of:

- the assumptions used for the expenditure, revenue and balance trajectory for the next four years submitted for parliamentary approval;
- the items determining the change in the expenditure of the various branches, by separating in particular the price effects from the volume effects;
- the loss of revenue, before any offsetting, linked to exceptional rules on deduction ("social niches");
- the performance of social security funds in the proper payment of benefits.

The framework for the financial management of social security needs strengthening

Other changes to the LFSS appear desirable:

- the establishment of an obligation for the Government to table, during the year, a draft amending law in the event of substantial questioning of the forecasts approved the previous autumn, as regularly takes place with the central government budget;

- the extension of forecasts to all social protection expenditure, particularly that of supplementary pension insurance and unemployment insurance, in order to make the scope of the LFSS coincide with that of the social security administrations (ASSO) used as part of the overall management of government finances;

- the strengthening of consistency between the LFSS and the multiyear public expenditure programming adopted by Parliament (public finance programming laws) or submitted to the European Commission (annual stability programme);

- the inclusion in the Budget Act of forecasts of structural efforts and balances;

- making any new debt takeover by the CADES concerning forecast deficits conditional upon the adoption of a path of recovery in the social security accounts.

Recommendations

3. To guarantee the coherence of the overall management of public expenditure, extend the scope of the social security finance acts to complementary and unemployment insurance schemes and link the annual and multiyear expenditure objectives of the social security finance acts to those of the government finances framework documents (programming laws, economic, financial and social report and stability programme) (ministry for social security, ministry for the economy and budget).

4. To shed light on the paths for the financial recovery of social security, integrate structural effort and balance forecasts into the social security finance acts and estimates of the structural effort and balance concerning the last financial year for the future laws approving the accounts (ministry for social security, ministry for the economy and budget).

5. Contribute to the management of the expenditure objectives set by the annual social security finance act and the public finance programming bill, by integrating into the budget bill and the future bill approving the accounts submitted for the Parliament's approval a summary table of the differences affecting the balance and a report proposing measures intended to offset them in whole or in part (ministry for social security, ministry for the economy and the budget).

6. Provide for an obligation to submit a Supplementary Budget Act when the conditions for financial balance adopted in the Initial Budget Act are called into question (ministry for social security, ministry for the economy and budget).

7. Incorporate the reversals of deficits by the CADES (debt reversals), when these operations concern provisional deficits, into a multiyear trajectory for the recovery of the social security accounts, by extending the exclusive domain of the social security finance acts to these recoveries and by submitting in this context to Parliament a report documenting recovery measures (ministry for social security, ministry for the economy and budget).

8. Improve the conditions for the exercise by Parliament of its constitutional mission of controlling social finances, notably by detailing at an appropriate level expenditure and revenue by type, by stating all of the assumptions underlying the multiyear financial trajectory and by stating all of the data in millions of euros, in the budget bills, as well as the approval of the accounts (ministry for social security, ministry for the economy and budget).

3 - Health insurance expenditure: a regulation requiring reform

In 2020, the Court highlighted in the report on the implementation of the social security finance acts the contributions of the establishment of the national healthcare expenditure target (ONDAM) and the associated regulatory mechanisms. It nevertheless stressed the importance of defining a multiyear programme capable of improving the quality of care while controlling its cost for the community.

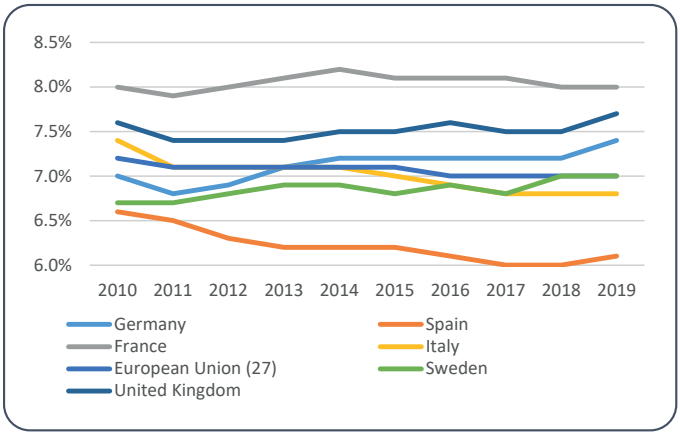
Once again this year, given the challenge and the difficulty of implementing these guidelines, the Court wished to explore the issue of regulating health insurance expenditure in greater depth.

The ONDAM: an essential framework to be supplemented

For around ten years and until just before the pandemic, the ONDAM and the associated regulatory tools made it possible to curb the rise in health insurance expenditure. Nevertheless, this remains at a very high level as a percentage of national expenditure.

Curb social security expenditure and indebtedness

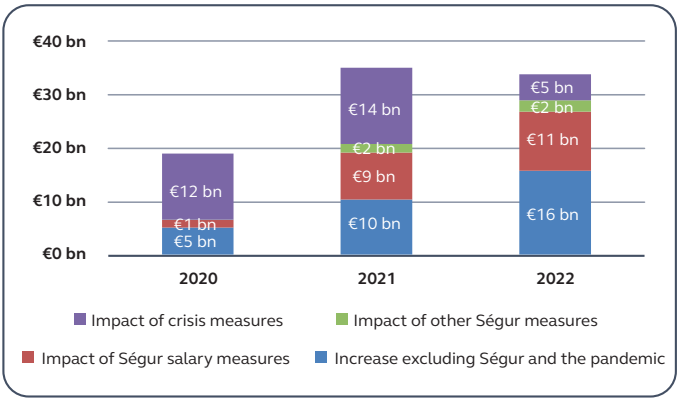
Public healthcare expenditure (as a % of GDP)



Source: Eurostat, "General government expenditure by function (COFOG)".

Furthermore, since 2020, the ONDAM no longer plays its role of supervising expenditure, given the exceptional measures taken to deal with the pandemic, and in particular the plan to increase the pay of workers in the hospital and medical-social sectors, as well as the exceptional effort to invest in the health system announced by the public authorities ("Ségur de la santé").

Share of the crisis and the "Ségur" in the increase in the 2020-2022 ONDAM



Source: Court of Accounts, according to responses from the administrations
Note: expenses with a constant scope during 2020. Under the assumption of a 2.6% increase in expenditure in 2022 with an unchanged policy before "Ségur" measures and taking into account the provision planned in the draft social security finance acts for crisis measures.

In addition, financial regulation has not been accompanied by a sufficient reform effort, particularly in terms of the relevance of care and the transformation of the healthcare system.

Insufficient relevance and efficiency of care in France: examples

Generics' share of the French pharmaceutical market (16% by value and 30% by volume in 2017) remains low compared to the OECD average (25% by value and 52% by volume) and our European neighbours (36% by value and 85% by volume in the UK; 35% by value and 82% by volume in Germany).

France is one of the OECD countries with the highest number of magnetic resonance imaging (MRI) examinations.

In terms of medical biology, the Court noted the effectiveness of the price-volume regulation introduced in 2014 to curb the rise in expenditure until 2018. However, based mainly on price reductions, this system has not made it possible to control the rise in volumes.

In hospitals too, a significant proportion of stays could be avoided. The difficulties encountered arise in particular from the lack of a care solution in downstream structures or in the home, which are often less costly for the community.

A link to be established with the objectives of the national health strategy

It appears more than ever necessary to include an ONDAM, redefined in its scope, in a more formalised regulatory framework in order to combine, from a multiyear perspective, compliance with the financial and health objectives set by Parliament.

The 2015-2017 ONDAM plan: an interesting precedent

For the 2015-2017 period, a specific effort was made to reconcile financial objectives and the national healthcare strategy through a multiyear savings plan known as the "ONDAM plan". A retrospective analysis of this plan, which was not presented in the budget documents, shows that the efforts made were significant, although they fell short of the initial intentions in terms of transforming the healthcare system. It is regrettable that the public authorities have not learned from this effort to reconcile the various objectives from a multiyear perspective.

Moreover, in a highly decentralised healthcare system determined by supply, controlling expenditure requires greater accountability of care providers, both in the outpatient environment and in hospitals, particularly concerning the relevance of care.

Given the multiple healthcare providers and the challenges of properly allocating resources within the healthcare system, it is necessary to develop and mobilise more broadly in a coherent manner all of the available regulatory tools (tariffs, funding allocations, activity authorisation, agreements and contracts with healthcare providers) to guide healthcare activities at the most relevant level – national or local as applicable – to ensure compliance with the financial and health objectives set by Parliament.

Recommendations

9. Broaden the scope of the ONDAM to include all healthcare expenditure covered by the social security branches and attach to it a limited number of additional objectives (ministry for social security and health, ministry for the budget).

10. Make the ONDAM part of a well-documented multiyear trajectory, documented in depth in connection with the healthcare strategy, and precisely justify any revisions relative to this trajectory (ministry for social security and health, ministry for the budget).

11. Link a significant portion of the remuneration of healthcare providers in the outpatient environment and hospitals to the achievement of relevant objectives and formalise a practice observation mission combining the expertise of the national health insurance fund (CNAM) and the national authority for health (HAS), notably through the publication of summaries (ministry for social security and health, CNAM, HAS).

12. Make pay rises conditional upon compliance with the ONDAM and place the corresponding amounts in the reserve each year (ministry for social security and health, ministry for the budget).

13. Strengthen the tools and prerogatives of the regional health authorities (ARS) to apply the orientations defined at a national level within the framework of the ONDAM, taking into account the necessary rebalancing between regions, through:

- the development of population allocations to the various sectors of care activities.
- regional allocations, created step by step from the regional intervention funds (FIR) and mobilised in a flexible way by the ARS to facilitate the local transformations of the different sectors of activity necessary for more effectively graduated and coordinated care (ministry for social security and health, ministry for the budget).

2 Exiting crisis management methods

Through three inquiries, the Court has drawn up initial assessments of the management of social security during the crisis. From the payment of benefits to the recovery of social security contributions, the easier use of telehealth tools and the temporary suspension of the regulation of expenditure in medical biology, the measures implemented have responded to emergency situations. However, they cannot continue as they are:

- the social security funds must return to management methods that take sufficient account of the levy recovery and control requirements;
- the use of telehealth must be refocused to facilitate access to care and coordination between healthcare professionals;
- medical biology expenditure must be regulated again while ensuring better support for innovative biology acts.

1 - Social security funds during the pandemic: initial findings

The Court wished to draw up an assessment – necessarily provisional – of the pandemic's impacts on the organisation, functioning, activities and operational results of the agencies of the general social security system that pay social benefits and collect social security contributions.

Continuity of services preserved thanks to exceptional measures

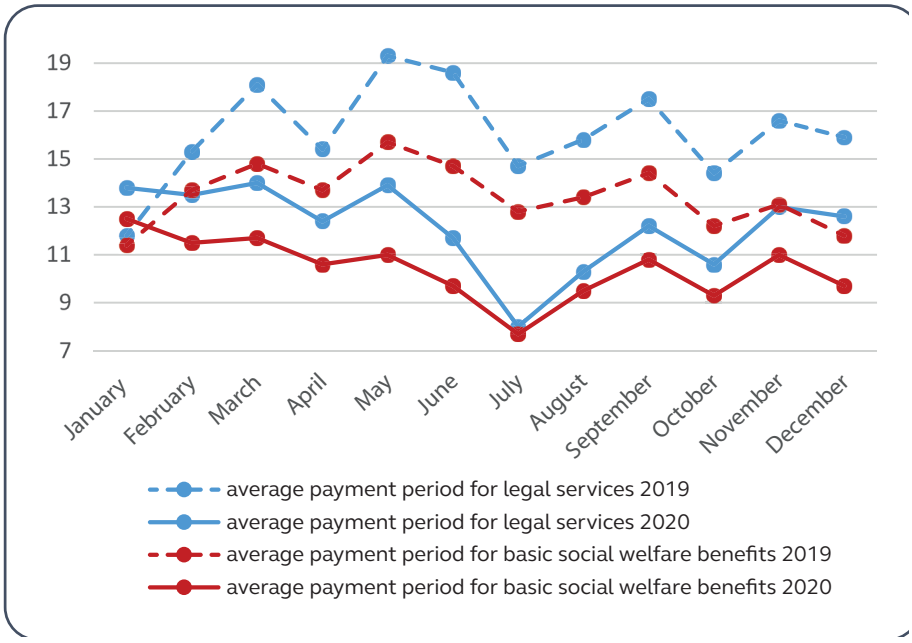
The social security funds were unprepared for the sudden nature and scale of the first lockdown, and had to quickly reorganise themselves. Remote working was the predominant method of activity throughout 2020. Over the year as a whole, the production capacity of most funds did not fall, despite the exemptions from paid activity granted during the first lockdown (temporary absence of a computer or the ability to connect to the funds' computer network).

Exiting crisis management methods

A priority was placed on the continuity of rights and the service of benefits, through measures to extend the rights of several millions of insured persons and beneficiaries, the redeployment of the funds' staff and by the reduction of controls.

On an annual average, despite their increase during the first lockdown (daily allowances in particular), the social security funds paid benefits in 2020 within normal, sometimes even improved deadlines, thanks to the maintenance of rights and the lifting of certain controls.

Average times (in days) for payment of legal benefits and basic social welfare benefits by the CAFs in 2019 and 2020



Source: Court of Accounts, according to data from the CNAF

The closure of reception centres during the first lockdown, the difficulty in accessing telephone reception services, which were in much higher demand than in 2019, and the digital orientation favoured during the crisis nevertheless affected access to social security for insured persons and beneficiaries not well versed in digital technology. The performance of telephone reception declined significantly at the healthcare and family branches.

Exiting crisis management methods

During 2020, nearly €200 million of additional administrative expenditure linked to the crisis was recorded. A significant proportion is linked to the search for cases of contact with people infected with the virus (contact tracing). Health insurance has invested heavily in this new public health mission (nearly 20 million people called at the end of August 2021 in total).

Actions to be stepped up to foster insured persons' use of their rights

The pandemic has enhanced the social buffer role played by the social security funds, in particular the family benefits agencies (CAF), which pay income support (RSA) and exceptional aid approved by the public authorities.

However, the duration of the crisis underlines the need for more active support for people in difficulty or individuals with an illness. By devoting this mission to positive law[3], the social security finance act for 2021 calls for a change of scale in the actions aimed at identifying people who are not exercising their rights to benefits or assistance.

Control mechanisms require a reset

At the same time, while they are insufficient in normal times in view of the extent of the risks of errors and fraud, on-site checks, as well as on documents, of the situation of those entitled to rights and benefits, which were sharply reduced in 2020, must be relaunched.

The amount of financial losses stopped by health insurance following litigation control actions fell by more than half in 2020 (€127 million, versus €287 million in 2019); these results mainly correspond to checks initiated before the pandemic. The health insurance agency should enhance checks on billing by healthcare professionals and relaunch those concerning activity billed by public and private healthcare agencies, which is no longer controlled at all. It is also important that the health insurance agency, as it has undertaken, makes the amounts of compensation for loss of activity (DIPA) paid to healthcare professionals under agreement more reliable.

Checks on the CAFs, which were reduced in 2020, also require wider deployment in view of the frequency of errors, both unintentional and intentional, made by beneficiaries in their declarations.

URSSAF checks must also be rearmed: in 2020, their checking actions – all actions combined – were halved compared to 2019 and the adjustment amounts in their favour fell by more than a quarter (€1.1 billion versus €1.5 billion). There are still insufficient efforts to identify short-time working fraud.

[3] New article L. 261-1 of the Social Security Code.

Exiting crisis management methods

Standardise the recovery of social security contributions

At the end of 2020, the recovery of social security contributions was in a very poor situation, mainly due to the application of very broad measures on payment deferral or tolerance concerning late payments.

Contributors' debts reaching considerable levels

At the end of 2020, unpaid amounts from private sector employers on contributions due in 2020 reached €11.4 billion (compared to €2.3 billion at the end of 2019), i.e. a deferred contributions rate of 4.5%, versus 0.9% at the end of 2019. Almost 41% of these employers' 2 million contribution accounts have deferred contributions.

Out of €15.1 billion in social security contributions called in 2020 on craftsmen, traders and liberal professions, €6.2 billion was not collected by the URSSAF at the end of 2020. At the end of 2020, the rate of deferred contributions therefore reached 41.1% of the amounts due, versus 10.1% at the end of 2019. As the contributions were called in 2020 on a basis of reduced professional income, in order to ease the cash flow situation of self-employed individuals, their 2020 professional income tax declarations submitted in May-June 2021 have resulted in even higher debts to the URSSAF in respect of 2020.

In mid-September 2021, the deferred contributions in respect of 2020 still reached €6.6 billion for private sector employers and €4.1 billion for self-employed workers. In 2021, other deferred contributions accumulated: at the beginning of September, €4.9 billion for private sector employers and €2.4 billion for self-employed workers.

The recovery in collection performance calls for better consideration of the economic situation of contributors by the URSSAF. To this end, the development of new synergies and cooperation between the tax authorities and the URSSAF should be conducted in greater depth so that the latter can, in particular, utilise on a large scale the infra-annual data on sales declared by a large proportion of contributors in their VAT returns.

Recommendations

14. Improve the business continuity plans of the social security funds by formalising reference systems for solutions that can be activated and by determining a priori the means capable of guaranteeing an immediate widespread rollout of remote working in major situations of unavailability of premises or absences (national agencies of the general social security system).

15. Immediately initiate new actions, based in particular on the use of data pooled between the social security funds and with central government administrations, necessary for all eligible persons to exercise their social rights, particularly for the benefit of complementary solidarity health insurance and basic social welfare benefits (national agencies of the general social security system).

16. Adopt on a larger scale the checks on the billing of healthcare costs by healthcare professionals and agencies to the health insurance agency, as well as checks on the basis of social security contributions declared by contributors (ACOSS, CNAM).

17. Use the data available from the tax administration to refine recovery actions regarding contributors (ministry for public accounts, ACOSS).

18. To ensure the proper payment of the compensation for loss of activity of contracted healthcare professionals (DIPA), systematically check that the declarations made by beneficiaries match the data held by the administrations that paid the financial assistance used to calculate this assistance, and recover all undue payments (ministry for social security, CNAM).

2 - Telehealth: tools to use to coordinate care

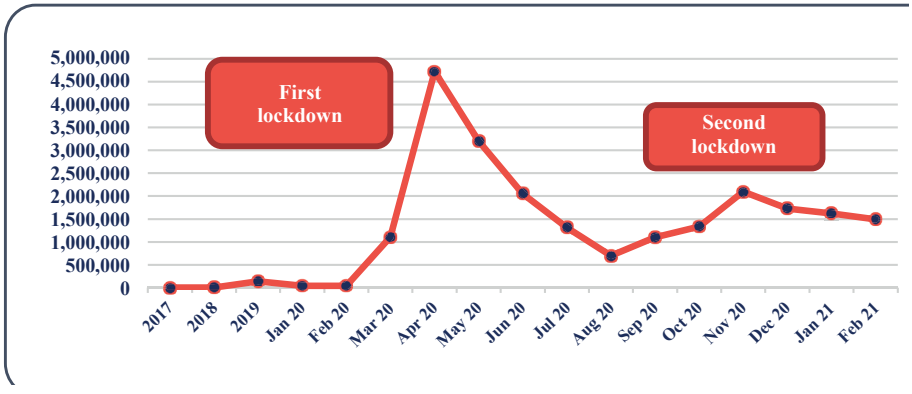
Compared to other countries, France has planned ahead for the emergence of telehealth rather well, with a legal framework for its use having been defined at the end of the 2000s. Various trials were then undertaken to seek to assess the improvements it brings in terms of access to care in areas lacking medical resources, or the coordination of healthcare professionals for patient care. The laborious conduct of these trials and the late registration, in 2018, of remote consultations for reimbursement by the health insurance office have slowed down their development during the last decade.

Remote consultations: a useful palliative measure during the pandemic

In 2020, due to the Covid-19 epidemic, the lockdowns and the general public's reluctance to go to the practices of non-hospital physicians resulted in the mass use of remote consultations, with the number increasing from less than 140,000 in 2019 to 18.4 million in 2020. Telehealth has been used in particular to monitor patients with Covid-19.

Change in the number of remote consultations (2017 - February 2021)

(in millions)



Source: Court of Accounts, according to data from the SNDS

Exiting crisis management methods

During the pandemic, various regulatory measures were taken by the public authorities to facilitate the development of remote consultations. As such, in April 2020, a decree authorised the reimbursement of remote consultations by telephone for certain patients who do not have access to the devices necessary for video transmission. These exemptions were thereby extended until 1 June 2021.

All of the remote consultation acts have, moreover, been fully reimbursed by the health insurance office (instead of 70% according to the conditions of common law). Justified, during the pandemic, by the time needed for professionals to acquire technical solutions enabling remote payment of the user fee by the patient, this exemption must not last, however, since there is nothing to justify telehealth acts being reimbursed to a higher level than identical acts conducted in the office of professionals or in patients' homes.

Telehealth to be used first and foremost for coordination and access to care

With a view to gradually exiting the pandemic, the Court wished to put the future of telehealth into perspective. It does not seem desirable to establish it as an additional method of conducting acts; on the contrary, its selective use should be encouraged, as part of policies for transforming the supply of care, to contribute to the coordination of care or better access to care. People living in areas with a low density of physicians, detained patients, residents of medical-social establishments or patients with chronic diseases should be the main beneficiaries of telehealth.

This requires, in particular, appropriate financing methods, particularly to contribute to the development of remote monitoring, support mechanisms, notably for liberal professionals, and a definition of the role of local organisations in telehealth, whether regional hospital groups, local hospitals or even coordinated exercise structures, such as local professional health communities (CPTS).

Lastly, the public authorities must continue to facilitate the acceleration of the technical work making it possible to put healthcare professionals in touch with each other and with their patients, and to exchange the data necessary for the care provided to patients.

Recommendations

19. Support the development of telehealth to ensure the coordination of care by mobilising as a priority the grouping of regional hospitals (GHT), local hospitals and coordinated practice structures and by providing, in the pricing reform projects, financing methods other than a fee-for-service system (ministry for social security and health).

20. Target aid policies for equipping the ARS and the CNAM on priority areas and audiences (ministry for social security and health, CNAM).

21. Strengthen the interoperability of telehealth information systems by making compliance with national standards binding and by including in them interoperability with connected medical devices (ministry for social security and health).

22. Evaluate the effects of the relaxations introduced by amendment 9 to the medical convention in terms of coordinated care pathways and prior knowledge of the doctor (ministry for social security and health, CNAM).

23. End 100% coverage (CNAM, ministry of solidarity and health) and develop a plan of post-audits on the billing of remote consultation acts (CNAM).

3 - Medical biology expenditure: efficiency efforts still insufficient

The medical biology sector underwent a major reform at the beginning of the last decade (order of 13 January 2010 and act no. 2013-442 of 30 May 2013). This reform strengthened medicalisation, placing under the responsibility of a biologist (doctor or pharmacist) all phases of an examination, from sampling to providing an interpreted result. It also submitted all of the laboratories to an accreditation procedure to guarantee the reliability of results. At the same time, the public authorities encouraged the grouping together of medical biology laboratories to achieve productivity gains.

After an initial investigation in 2013, the Court conducted a new investigation at the end of 2020-beginning of 2021, which led to the following findings.

The regulation of spending is not based on the search for improved prescription relevance

Until 2019, expenditure was curbed by a regulatory mechanism of a primarily financial nature, setting the standard for the increase in expenditure at 0.25% per year, in the form of three-year protocols concluded between the health insurance agency and medical biologist unions.

However, it was the reduction in the rating of acts that made it possible to comply with the expenditure budgets in 2016 and 2018. Between 2014 and 2018, these measures represented more than €440 million in savings.

While direct action on doctors' prescribing behaviour would be crucial, in 2019 the health insurance agency ceased all actions aimed at reducing the redundancy of examinations and irrelevant tests. It is essential to relaunch risk management actions, based on benchmarks that the HAS will have to define for common acts with the highest financial stakes.

In addition, the ability for biologists to modify the content of examinations to ensure the relevance of the acts performed has remained underused since it came into force in 2013.

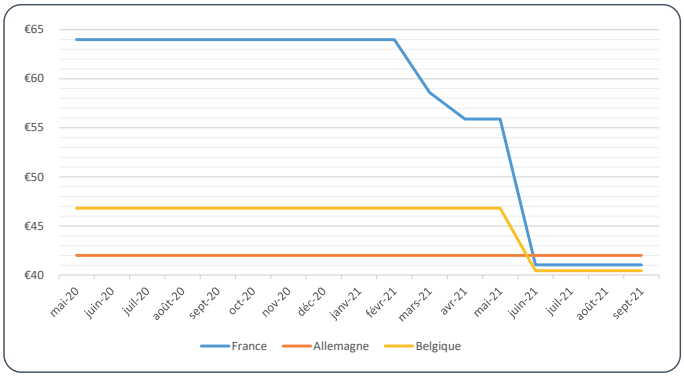
Suspended during the pandemic, regulation needs to be relaunched

At the end of December 2020, medical biology expenses in the non-hospital environment accumulated over the year (€4.96 billion) were 51% higher than in 2019. This dynamic is largely due to the widespread use of screening tests for the SARS-CoV-2 virus.

Faced with this exceptional situation, with expenditure unrelated to the epidemic crisis having decreased in 2020, the application of the three-year protocol concluded in 2019 was suspended in 2020. As such, there was no pricing adjustment in either 2019 or 2020. It was not until 2021 that the regulatory mechanism of the three-year protocol was reactivated, the CNAM having made pricing cuts, the principle of which had been decided in 2020 before the start of the pandemic, for a total amount of €85 million.

In addition, the high level of RT-PCR test prices, compared to those elsewhere in Europe, would have justified making an earlier decision on reductions. An additional cost of at least €800 million is attributable to the late and partial nature of the reduction measures.

RT-PCR test price in France, Germany and Belgium



Source: Court of Accounts

Shortcomings in terms of territorial regulation, quality and taking into account innovations in the nomenclature of medical biology acts

Since 2016, neither the National Medicines Safety Agency (ANSM) nor the Regional Health Agencies (ARS) have received any reports from the agencies responsible for laboratory quality control. The ANSM does not know which laboratories have not checked themselves. Since 2016, it has reduced the number of its staff assigned to this mission six-fold.

The ARS did not put themselves in a position to ensure, in view of changes in territorial density, the continuity of access to biological diagnostic capabilities. Between 2013 and 2020, despite the concentration in the sector, the relative stability of the local establishments of the sampling sites resulted in continued inequalities in access to the independent biology offering: the areas with the most laboratories are still the Paris region, Grand-Est, Nouvelle-Aquitaine and the PACA region, while under-dense areas remain the same.

Lastly, while the last decade has been marked by a continuous flow of innovations in the field of biology, the processes for registering for reimbursement and determining prices appear insufficiently responsive. Nearly 700 innovative acts have been accumulated over more than a decade, pending evaluations allowing their possible coverage by the health insurance agency and the setting of their reimbursement rates.

Recommendations

24. As part of the rollout of electronic prescriptions, ensure compliance with the obligation for prescribing physicians to communicate to biologists the relevant clinical elements (ministry for social security and health, CNAM).

25. To foster volume control, with relevance in mind, produce standards for common examinations with the highest financial stakes (ministry for social security and health, CNAM, HAS).

26. Reduce the evaluation time by 31 December 2024, by eliminating acts that have become obsolete or unnecessary and by integrating the others into the nomenclature of medical biology acts (ministry for social affairs and health, CNAM, HAS).

27. Maintain up-to-date and coordinated data on the territorial location of laboratories, their economic situation, and restructuring and concentration movements with a view to preserving local biology (ministry for social security and health, ministry for the budget, CNAM).

3 Relaunch and accelerate management reform and improvement projects

The pandemic has slowed the progress of many management reform and modernisation projects, which must be relaunched. It remains particularly necessary to transform the health system to ensure better healthcare for patients, fostering the continuity of the care pathways, the provision of care adapted to each individual's medical situation and taking medical innovation into account. This also applies to the controlled development of digital tools to improve the service relationship, the effective use of social rights and the reliability of the management of social benefits.

The Court illustrates these issues through the summaries of four enquiries on adapting the financing methods of healthcare establishments and medical-social establishments and services, paperless medical prescriptions and improving the management of certain social security or solidarity mechanisms, such as the recognition of and compensation for work accidents and occupational illnesses, the solidarity allowance for the elderly and the back-to-school allowance.

1 - Follow-up and rehabilitation care, psychiatric care, reception of dependent elderly people and people with disabilities: ten years of unsuccessful reforms in the financing of agencies and services

From 2003, the reform of activity-based pricing ("T2A") was implemented in hospitals and clinics, with each acute care stay in medicine, surgery and obstetrics (MCO) now being priced based on the same medical-economic nomenclature. The principles of these new funding rules inspired four major projects undertaken at the start of the last decade for the other activities of health establishments (follow-up and rehabilitation care, and psychiatric care), as well as for those of medical-social agencies and services (ESMS) for the reception of the elderly (nursing homes) or people with a disability.

Relaunch and accelerate management reform and improvement projects

Unsuccessful reforms

Convergent findings emerge:

- overall, aside from the elderly sector (90% of activity-based funding indirectly), activity's share of funding remains low: 31% follow-up and rehabilitation care, 8% psychiatry, 0% people with a disability;
- with the exception of those used to assess the medical burden of caring for dependent elderly people and which can still be improved, the pricing tools are not yet sufficiently medicalised;
- the principles of most projects have evolved to introduce differentiated allocation mechanisms for funding by region and territory, although these still need to be more firmly supported;
- the support for and organisation of the various projects is fragile;
- forward planning regarding the problem of managing the financial effects of the reforms is insufficient, the reform of long-term care packages for nursing homes had to be adapted in 2018 to take into account the difficulties of agencies whose resources were reduced due to the application of new rules;
- lastly, the financing reforms are carried out without sufficient links with the other tools for transforming the healthcare system (authorisation system, target and best efforts contract, etc.) and they are too often called upon to support objectives instead of other drivers that would seem more appropriate.

An increased cross-sectoral nature of the management of the various projects is necessary to ensure a better response to patient needs. As patients can successively be handled by different care sectors, the overall coherence of the reforms must foster adapted care, under a rationale of pathways and gradation, by promoting outpatient care in particular or home care.

Recommendations

28. By the end of 2024, develop, for each of the fields, the tools for measuring the extent of coverage with the aim of enriching the corresponding pricing models (ministry for social security and health, CNSA).

29. Extend to the follow-up and rehabilitation care sector and ESMS the legislative principle aimed at gradually correcting territorial inequalities through the distribution between regions of allocations, set according to transparent criteria (ministry for social security and health).

30. Set up a permanent cross-sectoral structure of "delegated project ownership", within the general secretariat of social ministries, in charge of supervising and coordinating pricing reforms (ministry for social security and health).

31. With a view to achieving more selective use of pricing incentives, establish upstream of the reforms the projected map of the use of the three main levers for transforming the offering: authorisations, multi-year target and best efforts contracts, and pricing (ministry for social security and health).

32. Adopt a rigorous methodological framework for financial simulations and consultations concerning reform projects and insert them into a pre-fixed timetable of a reasonable duration (ministry for social security and health).

2 - Medical e-prescription: a factor in the efficiency of the health system, ambitious projects to be completed

The switch to paperless medical prescriptions could enable major progress, particularly in terms of the quality and safety of care, the relevance and efficiency of health expenditure, the reduction of management costs and the prevention of errors and fraud.

Relaunch and accelerate management reform and improvement projects

Examples of the expected progress from e-prescriptions

E-prescriptions will make it possible to put an end to the difficulties stemming from the paper format of medical prescriptions: loss, damage and reading difficulties, which can cause medication errors.

They could encourage the development of prescriptions of drugs with a non-proprietary name, in principle mandatory, and of generic drugs, with France lagging behind in this area (one in three boxes issues, versus four in five in the United Kingdom). To e-prescribe, doctors will have to use prescription support software.

These will eliminate certain risks of fraud and errors: the absence of an effective prescription, the surcharge or reuse of a prescription several times in several different pharmacies, the backdating of prescriptions and discrepancies between billing by health system stakeholders relative to prescriptions.

They will enable the health insurance agency and healthcare professionals to achieve productivity gains on administrative tasks.

A lot of ground to make up

Currently, the health insurance agency offers e-prescription remote services only for sick leave and patient transport. They are still underused.

Most medicine prescriptions have switched to paperless in Belgium, Spain, Italy and the United Kingdom, in some cases several years ago, while in France they are still only paper-based.

France is aiming to catch up in e-prescriptions. Pursuant to the law of July 2019 on the organisation and transformation of the healthcare system, doctors will have to e-prescribe sick leave by the end of 2021 and all other prescriptions by the end of 2024. However, only part of the implementing texts have been adopted to date.

The risk of e-prescriptions in a non-optimal scope and mode

However, these timetables seem very ambitious. In the first half of 2021, just 54% of notices for sick leave and maternity leave issued by non-hospital physicians were paperless. Following trials, the health insurance agency must set up new e-prescription remote services from 2022 and non-hospital and hospital physicians must adapt in order to use them.

Medicine prescriptions could switch to paperless fairly quickly, although in a non-optimal mode that would not enable much of the expected progress to materialise (see inset): lack of codification of the dosage and duration of the prescription or use of the international non-proprietary name, with the trade names remaining

in use; lack of interoperability of the software used by various healthcare professionals limiting the services offered to patients.

While hospital prescriptions fulfilled in the non-hospital environment (PHEV) represent a significant part of non-hospital spending (22% in 2019), prescriptions for sick leave at the end of a hospital stay are not subject to the e-prescription obligation. Obstacles could hinder the compulsory e-prescription of other PHEVs: the lack of authentication of effective prescribers and the lack of connection of hospital information systems to the health insurance agency's e-prescription remote services.

According to the texts in force, taxis and service providers and distributors of medical devices will not be required to send to the health insurance agency e-prescriptions issued by doctors.

Recommendations

33. Extend the scope of the obligation to digitise prescriptions to all healthcare acts, goods and products prescribed and performed or dispensed by all stakeholders in the health system in the non-hospital environment and hospitals, by remedying several omissions (sick leave prescribed in healthcare agencies, transport by approved taxis and medical devices marketed by service providers) (ministry for social security and health).

34. Adopt non-commercial references for the e-prescription of medicines and medical devices and define methods for codifying the paperless prescriptions for acts involving biology, paramedics and other doctors (ministry for social security and health, digital health agency, CNAM).

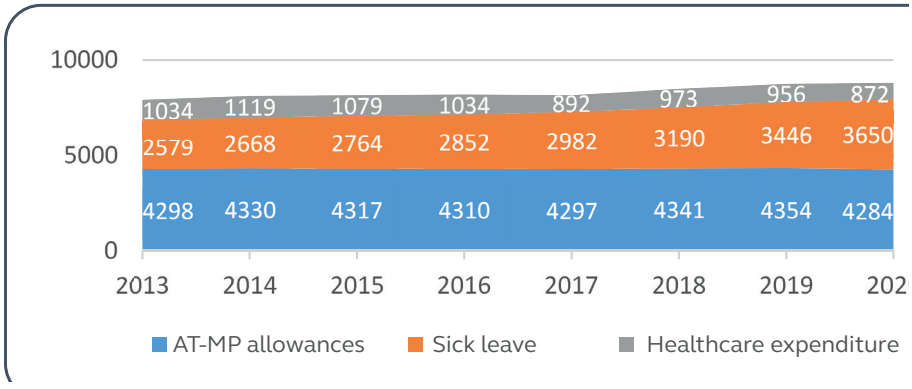
35. As part of the programme that will take over from Hop'en in 2023, guarantee the connection of hospital information systems to the e-prescription services set up by the health insurance agency and effective individual authentication of professional prescribers in hospitals (ministry for social security and health, CNAM).

3 - Recognition and compensation for work accidents and occupational illnesses: a complex system that needs to be modified

For the 18.8 million employees affiliated with the general social security system, the work accidents-occupational illnesses branch (known as the "AT-MP branch") covers, according to complex rules, the consequences of incidents recognised as being occupational in origin. Recognition of the link with work usually takes place based on a simple presumption of liability without fault of the employer, which exempts the employee from establishing a fault of the employer and a causal link with the damage suffered. In return, the law provides for fixed and partial compensation for the damage suffered by the worker, funded exclusively through contributions paid by employers.

In 2020, the AT-MP branch recorded €13.4 billion in expenses, mainly relating to temporary incapacity and permanent inability to work. The healthcare costs, which are fully covered by the AT-MP branch, are imperfectly identified, with some proving to be unduly borne by the healthcare branch.

Services provided by the AT-MP branch (in €m)



Source: Court of Accounts, according to the annual financial statements.

Relaunch and accelerate management reform and improvement projects

Two main findings were drawn up by the Court of Accounts.

Insufficient priority placed on actions enabling temporarily incapacitated employees to return to work

Unlike most European countries (there are many examples: Switzerland, Germany, Sweden, Denmark, Austria, etc.), the compensation is mainly financial. It has little to do with helping victims of work accidents or occupational illnesses return to work. This long-standing observation is still valid because of a lack of coordination between public and medical stakeholders (ministry of labour, occupational medicine, ministry of health, health insurance agency, general practitioners), with businesses not involved to any significant degree. However, there are two issues at stake: the interests of individuals – through the restoration of their ability to work – to maintain their employability over the long term and the control of expenditure on compensation for sick leave, which is particularly dynamic.

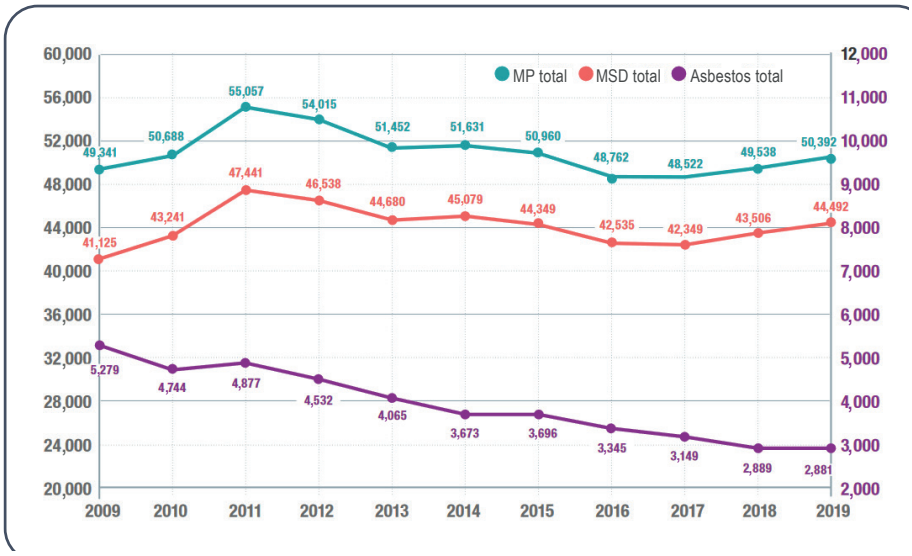
A management characterised by some conservatism, which perpetuates a great deal of complexity

The framework for managing the recognition of occupational illnesses is in dire need of flexibility, with an abundant system of committees that does not foster the necessary changes to the "tables of occupational illnesses". The case of musculoskeletal disorders (MSDs) illustrates this situation. In France, they account for 85% of recognised occupational illnesses, which is a very unusual figure compared to other European countries.

The atypical application of the principle of presumption to MSDs

Overall, per 100,000 insured individuals, 258 occupational illnesses are recognised in France, versus 81 in Germany. This difference is mainly due to the implementation, in France, of the principle of presumption through the tables for diseases whose causes are nevertheless multi-factor, particularly for MSDs (such as lower back pain and carpal tunnel syndromes); 227 cases are recognised in France per 100,000 insured individuals, versus just 4 in Germany.

Recognition of occupational illnesses (by number of illnesses)



Source: The health insurance agency – Occupational risks, 2019 annual report

The determination of the permanent incapacity rate, which is used to calculate the allowances paid to people who still suffer from significant after-effects, must be revised, both by updating the regulatory scale but also through management instructions given to the medical advisors of the health insurance agency (for some conditions, e.g. chronic respiratory conditions, an extremely wide range of incapacity rates attributed ranging from 10% to 100% was found).

Lastly, the modernisation of administrative management deserves to be accelerated in many respects: the allocation of pensions must be optimised to avoid disrupting resources for the insured persons concerned; the use of paperless procedures must become the norm (medical certificates, work accident declarations, sick leave notice); the data from the nominative social declaration (DSN) must be able to be used to determine the base of the allowance; teams from the medical service must be grouped together in specialised centres with those of the primary funds to improve the management of the recognition of occupational illnesses and the management of allowances.

Recommendations

36. Control and improve the methods of charging healthcare costs to the AT-MP branch (ministry for social security and health, CNAM).

37. Accelerate the necessary adaptations of the existing tables of occupational illnesses by providing in particular for their implementation by a decision of the Director General of the CNAM after consultation with the AT-MP commission (ministry for social security and health, Secretary of State for pensions and occupational health, CNAM).

38. Standardise, notably through a change to the scale, the determination of the incapacity rate and the listing of situations likely to justify the application of a professional coefficient (ministry for social security and health, CNAM).

39. Make the support for returning to work more effective through early intervention with employees, in conjunction with their attending physician, by involving the employer and the occupational health services (ministry for social security and health, Secretary of State for pensions and occupational health, CNAM) during the sick leave.

4 - The basic old-age pension and the back-to-school allowance: a strong contribution to poverty reduction, mixed management performances

The basic old-age pension, allocated since 2007 in the form of the solidarity allowance for the elderly (ASPA), and the back-to-school allowance (ARS), created in 1974, are two non-contributory solidarity mechanisms, significant both in terms of the number of beneficiaries concerned (750,000 elderly households and three million families) and the increasing amounts provided, supported by the social security system (respectively €3.9 billion and €2.6 billion in 2020). The Court considered it interesting to conduct a descriptive comparative analysis of these two mechanisms.

Relaunch and accelerate management reform and improvement projects

Two allowances designed to provide additional resources to households and families on very low or modest incomes.

The main rules for allocating the ASPA

The beneficiary must have liquidated their pension rights, be 65 years of age or over (62 in the event of inability to work or permanent incapacity of at least 50%) and legally reside in France for at least six months per year.

The allowance takes into account all of the household's resources (except housing allowances). It is referred to as differential, being equal to the difference between household income and the cap on the allowance (€906.81 or €1,407.82 for a couple as of 1 January 2021). The basic old-age pension allowances result in a recovery being claimed on the beneficiary's estate from the heirs or beneficiaries for the proportion of the inheritance exceeding €39,000 (€100,000 overseas). The amount of the recovery is capped at €7,354.12 per year for a single person and €9,838.68 for a couple.

The amount of the ARS varies depending on the age of the children (€370.31 for primary, €390.74 for middle school and €404.28 for secondary school). The allowance is subject to means testing.

The caps are set according to the number of children, but are unrelated to the number of working people in the family. They are higher, for couples, than the floors corresponding to the so-called poor and working-class income classes, and average for single-parent families.

Two regularly upgraded mechanisms helping to reduce poverty

The basic old-age pension and the ARS are indexed to inflation. However, the former has been exceptionally revalued (50% increase between 2005 and 2020) and the latter saw an exceptional increase of €100 in 2020.

The poverty rate for retirees aged 65 and over, defined as the proportion of people with a standard of living below the poverty line, among retirees aged 65 and over was 8.7% in 2018, a significantly lower rate than among the general population (14.8%). Among the eight European countries studied, the poverty rate for people aged 65 or over is the lowest in France (more than ten points lower than the poverty rate for those under 18).

The ARS also helps to reduce the precariousness of low-income families. According to the national family allowance fund (CNAF), it decreased for its beneficiaries, by 2.5 points in 2019, the proportion of those living below the poverty line, thereby

lowering it from 41.2% to 38.7%. It is one of the most generous back-to-school assistance schemes among those introduced by OECD countries: relative to the minimum wage, the amount of aid is among the highest in France, representing a quarter of the amount of the gross minimum wage, versus 10% in Germany.

However, changes to the systems are desirable

The rules for allocating the basic old-age pension, which are very complex, should be simplified, which would make it possible to reduce the causes of errors and fraud.

ASPA: a high error rate

The frequency of errors continued to increase in 2020, reaching 23.8% for the ASPA. As such, nearly one in four liquidations included at least one error causing a financial impact, at the beneficiary's expense in 75% of cases. Almost three quarters of fraud detected in the old age branch concern the basic old age pension, mainly for breach of residence or resource conditions, the management bodies of which stress the complexity and difficulty of conducting checks.

This simplification would also make it possible to facilitate the provision of information to the public, as a large proportion of people do not exercise their entitlement to the allowance. According to a study by the national old-age insurance fund (CNAV), the rate of non-use was between 34% and 49% depending on the assumptions used. Direct questioning of 350 of these insured individuals showed that three quarters of them could claim the ASPA and that half did not know about this system or were not very familiar with it.

The ARS: a mechanism whose management must remain simple

However, the ARS amounts are weakly modulated according to children's age. All of the available studies show that the expenditure increases significantly alongside the level of schooling, varying from single to double between a primary school pupil and a secondary school student. The benefit of the back-to-school allowance could therefore be refocused on families on the lowest incomes and the scale of the back-to-school allowance would also benefit from being adjusted, at a constant cost, to more effectively cover expenses related to the education of older children.

Recommendations

On the solidarity allowance for the elderly:

40. More effectively integrate the specific characteristics of the ASPA into the definition and implementation of internal control systems and measure their effectiveness through a specific residual risk indicator, the analysis of which will improve the quality of liquidation (ministry for social security and health, pension funds).

41. Draw on the data analysis to identify potential beneficiaries of the ASPA and strengthen information actions aimed at them, with the aim of reducing the rate of non-use (ministry for social security, pension funds).

42. Undertake a project to simplify the rules governing the ASPA and step up work on the digitisation and automation of its management processes (ministry for social security and health, FSV, pension funds).

On the back-to-school allowance:

43. As soon as possible, use the monthly resources system (DRM) to allow more recent resources than those of year Y-2 (CNAF) to be taken into account.

44. Study, for the sake of consistency and simplification, the abolition of the tax reduction for tuition fees in secondary education and the redeployment of the expenditure, at a constant budgetary cost, to adjust the amounts of the ARS awarded to middle school and secondary school students from low-income families (ministry for social security, ministry for the budget).