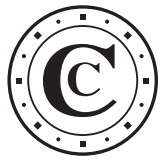
Cour des comptes



ENTITIES AND PUBLIC POLICIES

THE ADULT DISABILITY ALLOWANCE

Public thematic report

Summary

November 2019

DISCLAIMER

This summary is intended to facilitate the reading and use of the report of the Cour des comptes.

Only the response of the Prime Minister is provided at the end of the report.

Summary

Introduction

Introduced in 1975, the Adult Disability Allowance (AAH) was designed to provide a minimum income for individuals with disabilities who do not receive an income through employment. The monthly amount paid is €900. For recipients living alone who receive income support in addition to the allowance, the AAH may be as much as € 1,040 per month, i.e. almost double the RSA (revenue de solidarité active, Active Solidarity Income).

Entirely funded by the State, AAH-related expenditure amounted to €9.7 billion in 2018 and could reach €10.3 billion in 2019. With more than a million recipients, the AAH is therefore France's second most significant minimum social benefit. It alone accounts for 35 % of the €26.5 billion dedicated to these systems in 2017 and it is, in fact, both one of the main instruments of the policy to combat poverty and a key element of the policy on disability.

Although it was introduced some years ago, there has been a steady increase in the number of applications for AAH since its introduction, an increase that has grown over the past decade. Between 2007 and 2017, there was a regular average annual increase in expenditure of around €400 million, i.e. + 70 % over ten years.

There are actually "two separate AAHs":

- the AAH-1 for individuals whose recognised incapacity is greater than 80 % (severe disabilities); the number of recipients of this allowance is growing at about the same rate as the population;

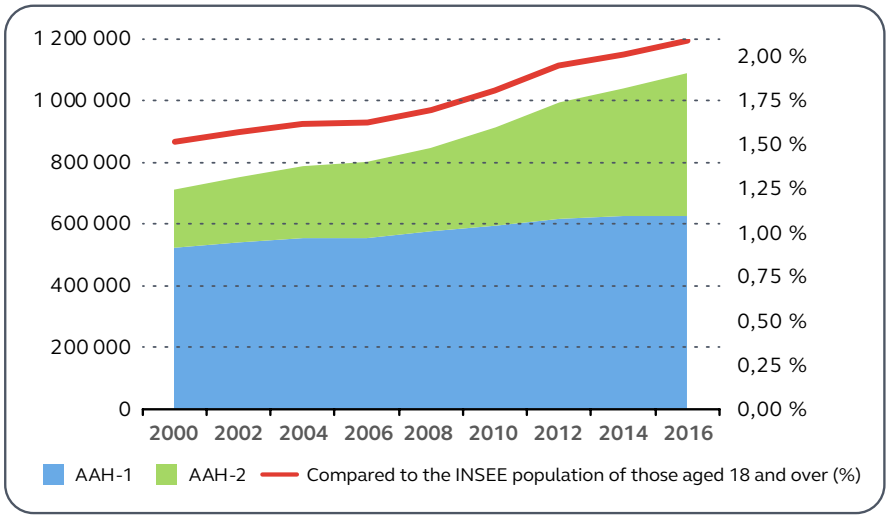
- the AAH-2 for individuals whose incapacity is assessed at between 50 % and 80 % and who are considered to have very limited access to employment: the number of such recipients has been increasing by 7 % per year since 2008.

The number of recipients of the AAH-2 has thus doubled since 2008. With more than half a million individuals concerned, recipients of the AAH-2 now represent almost half of all recipients of the AAH.

The Cour des comptes (Court of Audits) has already devoted a number of publications to the AAH since 2005, but it had not yet provided an overview of this allowance. The report expands and complements this work, providing an analysis of the overall concept of the AAH, its specific allocation procedures and its management.

Introduction

Comparative growth in numbers of recipients of the AAH and members of the population aged 18 and over



Source: Cour des comptes, according to DREES (The French Directorate for Research, Studies, Evaluation and Statistics) 2018 and INSEE (The French National Institute of Statistics and Economic Studies)

The concept of disability has changed considerably since the early 2000s

For some twenty years, academic research carried out by international bodies such as the World Health Organisation and the UN has proposed a new definition of disability. This is based on impairments (which may be psychological as much as physical) which, combined with external or environmental factors unrelated to the individuals concerned, create impediments to their autonomy or affect the quality of their daily or social lives. It is now this combination of factors that constitutes a "disability", rather than merely an incapacity that can be assessed objectively via a medical diagnosis.

This conceptual evolution has considerably broadened the scope of disability. According to the broad definition adopted by the direction générale de la cohésion sociale (General Directorate for Social Cohesion, DGCS), 12 million individuals in France appear to be affected by disability. This new definition was introduced into the Social Security Code and the Social Action Code by the loi d'orientation sur le handicap (Disability Guidance Act) of 11 February 2005[1]. This important development has gone relatively unnoticed and the widely-accepted definition of the term "disabled" still refers to a medical condition and to the idea of severe and irreversible physical or mental impairment.

[1] Act No. 2005-102 of 11 February 2005 on equal rights and opportunities, participation and citizenship for persons with disabilities.

Broadening the concept of disability conflicts with the need to make eligibility criteria as objective as possible

The difficulty or even impossibility of establishing objective criteria to describe applicants' individual circumstances explains the great disparity in départements' AAH allocation rates. This is only partly attributable to the socio-demographic characteristics of populations and often reveals different interpretations of the scope of the 2005 Act and its implementing legislation.

While a certain level of diversity has always been observed in terms of decisions and practices — including, prior to 2005, between the commissions techniques d'orientation et de reclassement professionnel (Technical Commissions for Guidance and Occupational Rehabilitation, COTOREP) — the differences are now so great that they raise issues of regional equity and equal entitlement for individuals with disabilities. The DGCS has made genuine efforts to clarify concepts and provide decision support tools, but these appear to be structurally ineffective.

There is a particularly poor level of awareness regarding recipients of the allowance and their disabilities. Even at a very general level, the identification and coding of impairments encountered are rarely carried out by the maisons départementales des personnes handicapées (MDPH), despite the fact that this statistical follow-up has been mandatory since 2005. The forthcoming harmonisation of MDPH information systems will not fundamentally improve the situation since it will have no immediate impact on individual départements' coding practices. The target of a complete set of coded information will at best be identified from 2020 within multiannual agreements negociated between départements and the CNSA (National Solidarity Fund for Autonomy).

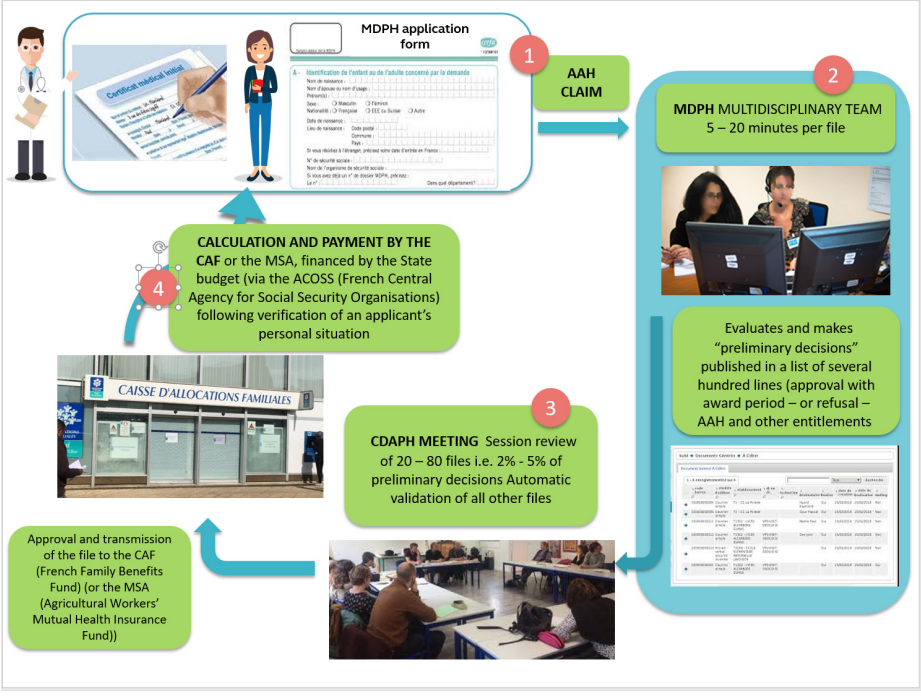
An original but also restrictive form of co-management in conjunction with associations representing individuals with disabilities

Up until 2005, the AAH was awarded by the COTOREPs, joint bodies established in 1975 whose composition had evolved to include representatives from the départements. Their central stakeholder was the State, which provided the resources that allowed these bodies to operate.

In 2005, the new Disability Guidance Act reviewed the AAH eligibility criteria. Awards are now based on decisions made by the commissions départementales des droits et de l'autonomie des personnes handicapées (Départements' Commissions of Rights and Independence of People with Disabilities, CDAPH) whose secretariat is managed by the maisons départementales des personnes handicapées (MDPHs), Public Interest Groups (GIPs) whose members consist of the State, the départements and associations representing individuals with disabilities. The latter have taken on a central role at various levels in the design and execution of policies created in their own interests. This situation, which gives real meaning to the slogan "Nothing For Us Without Us", also places constraints on the public authorities, the State and the départements. In recent years, it has proved very difficult to undertake any reform of the AAH, despite a number of recommendations from the Cour des comptes, the general inspectorates and parliamentary reports.

Decision-making within the MDPHs and CDAPHs now takes place according to a process that could be described as mass processing, in which the State merely provides the funding

The AAH decision circuit



Source : Cour des comptes

Decision-making within the MDPHs and CDAPHs

In 2017, the MDPHs received 4.5 million different claims and prepared 550,000 decisions regarding the AAH; other claims concerned the prestation de compensation du handicap (Disability Compensation Benefit, PCH), disability cards, applications for Disabled Worker status, etc. This activity is steadily increasing. At the same time, MDPHs are required to respect response deadlines of under three months. To cope with this double constraint, the MDPHs have "industrialised" their decision-making process. They have implemented a method for reviewing applications which is characterised by the need for speed and fluidity, and which has impacted on the conditions under which applications are examined.

The CDAPHs thus validate 95% to 98% of the preliminary decisions issued by MDPH teams in session and without scrutiny, and the State's presence within these commissions no longer has any real implications. On average, CDAPHs generally valididate around 1,100 decisions per meeting.

At its core, the allocation system is thus in fact based on single prior appraisals carried out by assessment teams within MDPHs. These teams are composed of widely varying numbers of individuals (frequently two people, sometimes a single individual, sometimes a broader team) and profiles (the presence of a doctor is far from systematic). They examine the documents supplied (the form completed by the applicant, the medical form completed by a doctor freely chosen by the applicant and, where applicable, medical test results). The time devoted to individual applications may vary between five minutes and twenty minutes per file. Medical examinations and even interviews are now rarely arranged, or only in exceptional cases since MDPHs are also experiencing considerable difficulties in recruiting and retaining doctors. When these do take place, they are frequently concerned with the prestation de compensation du handicap. Following this procedure, which usually takes place online, proposals submitted by MDPHs are in reality preliminary decisions validated in blanket fashion by CDAPHs without any particular intervention by State representatives.

An absence of mechanisms for detecting fraudulent applications

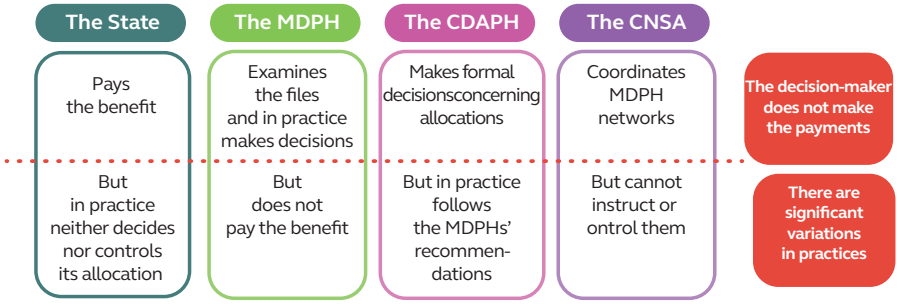
MDPH teams are required to make their decisions concerning AAH awards and renewals almost exclusively on the basis of various declarations (medical certificates issued by doctors chosen by applicants, application forms), which are not subject to any specific control mechanism. This situation presents a risk in terms of fraud. Checks carried out by the caisses d'allocations familiales (CAF) or caisses de mutualité sociale agricole (MSA) – payment agencies who are not responsible for decisions – only relate to criteria regarding the income or employment of recipients, and not to their eligibility for the allowance or to assessments of their disability. The organisation is not designed to detect and prosecute potential intentional fraud (certificates issued under false pretences, false records, false declarations).

This report concludes that a "blind spot" exists where efforts to combat fraudulent AAH claims are concerned. Whilst the MDPHs' work cannot be based on suspicion, it must however be acknowledged that the procedure presents specific risks, particularly since it is now carried out online and there are no direct interviews with applicants. In this respect, substantially less control, follow-up and monitoring is applied to the AAH than to other minimum social benefits, including the RSA.

The AAH lies at the heart of issues relating to the division of responsibilities between the State and the *départements*

Whilst the départements lead disability policy, the AAH remains a national benefit financed entirely by the State via budget funding. The present organisation thus appears paradoxical since, at the same time, the départements are financing the RSA: the coexistence of the AAH and the RSA necessarily raises equity issues where the unit amounts paid under the former are significantly higher than those paid under the latter, and where the scale of transitions from one to the other – around 25 % of new recipients of the AAH previously received the RSA – shows that the parameters separating the two allowances are blurred. Added to this lack of clarity is the fact that the départements – which bear the financial burden of the RSA – may have an immediate financial interest in ensuring that their RSA claimants' payments are superseded by the AAH; the social problems of such claimants tend to be combined with psycho-social problems and may now fall within the scope of disability as redefined in 2005.

The division of roles as regards the AAH



Source : direction du budget

The AAH lies at the heart of issues relating to the division of responsibilities between the State and the *départements*

The State is nevertheless making efforts to lead the AAH system at a national level by producing reference texts and clarifying certain concepts such as “permanent and substantial restrictions on access to employment”, the condition for granting the AAH-2. However, its leadership has proved to be ineffective in the absence of a strong local presence and the State has become relatively resigned to the rapid growth in the number of individuals receiving the AAH, in particular the AAH-2. It thus finances expenditure over which it has little or no control, expenditure which is increasing by €400 million every year. The départements and disabled persons’ associations are not directly affected by the budgetary aspect of the system as a whole or the rapid annual growth in its cost. With regard to the AAH, no single stakeholder appears to be responsible for the fair use of public funds or for regional equity.

An imperative need for reforms

The AAH-2 in its present form is a source of uncertainty and even budgetary risk, in that the numbers of recipients and the costs associated with these benefits are increasing on a yearly basis, in far greater proportions than can be accounted for by demographic trends alone, and for which the reasons are unknown. More generally, the AAH's allocation procedures raise issues of regional equity and equal entitlement. For these two reasons, reforms would appear to be imperative, whether within the framework of an organisation that is to remain unchanged – in which case management and monitoring arrangements will have to be significantly strengthened – or within the framework of larger projects that have already been announced, such as the revenu universel d'activité (Universal Activity Support, RUA), and a review of the responsibilities assigned to the départements under the regional organisation of the State.

Regardless of the direction taken, the Cour has identified the following recommendations as likely to improve the functioning of the system, in terms of both regional equity and entitlement to the AAH.

Recommendations

1. Within budget documents (PAP – Annual Performance Projects, and RAP – Annual Performance Reports), provisions made for the AAH-1 and the AAH-2 should be presented separately, along with details of all the elements taken into consideration when forecasting expenditure.

2. Consistency should be re-established within the official scale, between its general introductory principles and developments based on type of disability, with the stipulation that the threshold of 50 % incapacity is only reached where significant difficulties are experienced within the three areas of daily, social and professional life.

3. Within the framework of contractual relations with the CNSA, financial penalties should be imposed on the MDPHs for their failure to comply with their legal obligations regarding statistical monitoring, for example through a mechanism for withholding funds.

4. The granting of the AAH-2 should be made conditional on appropriate medical and social care, where possible.

5. An employability assessment interview should be introduced, prior to the granting of the AAH-2.

6. At least one medical check-up should be made mandatory, prior to the initial granting of the AAH.

7. Mechanisms for the monitoring of entitlement should be introduced, by systematising internal inspections within MDPHs and creating a national medical inspection mission.

8. All new applications for the AAH should be examined during CDAPH sessions.

9. The majority of CDAPH votes should be given to the State as funder of the allowance, regarding decisions relating to the AAH.