Summary

Social security

2012 report on the application of the laws for financing social security

September 2012

Notice

This summary is designed to make the Cour des Comptes report easier to read and use. The Cour des Comptes is responsible only for the content of the report. The responses of government departments, councils and other organizations are appended to the report.
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The annual report on the application of social security financing laws presents the results of the work carried out by the Cour des Comptes on social security.

Social security accounts that are unbalanced in the long-term and require a wide-ranging effort

The deficit of the general scheme and old-age solidarity fund (fonds de solidarité vieillesse, FSV) showed a decrease in 2011 but remained very high, despite compliance with the national objective for health insurance expenditure (objectif national des dépenses d’assurance maladie, ONDAM) for the second consecutive year. At -€20.9 billion, it is more than double what it was for 2007-2008. Based on its work of certifying the accounts of the general scheme, the Cour des Comptes has issued its opinion on the balance sheets and asset table attached to the draft social security financing law that confirm the extent of deterioration in the social security accounts.

The majority of the work required to balance these accounts remains to be done. For 2012 and subsequent years, despite new revenues approved over the summer, forecasts are for deficit reduction to slow down, with a general scheme deficit nearly €1 billion higher than forecast in the 2012 financing law and the need to take on new debt on behalf of the health care and family divisions, which are likely to exceed €9 billion. Nearly €60 billion in social security debt could accumulate between now and the end of the decade, over and above the €62 billion that the law has already set aside to transfer to the social security debt reimbursement fund (caisse d’amortissement de la dette sociale, CADES) on behalf of the old age division and FSV between 2011 and 2018.

If a committed effort towards recovery is not implemented quickly, social security debt will continue to grow even though it constitutes a serious anomaly and cannot continue to be passed on to future generations. All public tools should be used to act. In an attempt to make choices clearer, this report from the Cour des Comptes has reviewed €80 billion in revenues and €40 billion in expenses.
Reforms with uncertain effects

The Cour des Comptes has investigated the contribution of organisational and structural reform in balancing social security finances.

The financing of social security through dedicated taxes represents 12% of revenue from basic schemes and, along with social security contributions and the general social contribution, constitutes the third pillar of social security resources. A comprehensive discussion is required to clarify the place of this unstable bundle that does not favour accountability in the system for financing social security.

The reform of the special pension scheme for the SNCF and the RATP has partly achieved its aim of harmonisation with the civil service, but with high additional costs for companies, and a very limited effect on balancing the schemes. The creation of a social security scheme for self-employed workers at the end of 2005 and the establishment of a single system for collecting contributions caused major problems for many people insured by the social security system and resulted in a reduction in revenue (€1-1.5 billion by the end of 2010), with a negative impact on social security accounts.

The regional health agencies created in 2009 have been installed in satisfactory conditions, but less centralised management, progress in positioning and appropriate resources are essential for them to be fully successful in their missions, especially improving follow-up care and rehabilitation, which should cost the health care insurance system (Assurance maladie, AM) €7.8 billion in 2012.

Multiple tools for optimising the health care system

AM’s assuming responsibility for social security contributions of registered independent health care workers should be used more proactively to achieve AM’s main objectives; in particular, improved distribution of health care professions and limiting exceeding standard fees.

The role of the French National Medical Association (Ordre national des médecins, ONM) in ethical oversight and tact in determining fees is too limited a scope.

For the transport of patients covered by AM, the Cour des Comptes estimates possible savings of at least €450 million per year, or 13% of overall expenditure (€3.5 billion) that continues to grow.

The certification of public and private hospitals by the French National Health Authority (Haute autorité de santé, HAS) has shown marked progress but its selection and how it is taken into consideration in hospital performance contracts can be improved.
Solidarity with retirees and families

The Cour des Comptes has analysed the contrasting conditions of retired people. The minimum old-age pension plays an essential role in limiting poverty levels among the most vulnerable retirees, which makes it imperative to resolve the imbalance in the FSV that funds it. From an overall financial perspective, however, the retired population is currently in a slightly better situation than the working age population, especially the youngest group. The Cour des Comptes thus believes it necessary to reconsider certain tax expenditures and social niches that benefit from the current system, whilst protecting the most vulnerable retired individuals, in order to redirect resources towards those currently in need of support.

For family policy, the Cour des Comptes recommends an overall economic review of all supports that are limited by resources, which are found to have a limited effect in terms of reducing income inequality.

Savings required in social security management

The Cour des Comptes examined the information systems of the family division of the programme and recommends an in-depth redefinition of its strategic aims and how it is directed and managed. Regarding the system of daily allowances for illness, provided by the general scheme (€6.4 billion in 2011), it proposes a much firmer strategy for beneficiaries, companies and the medical sector, as well as further simplification and stepping up audits and the battle against fraud.

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Substantial progress in improving the efficiency of social security spending is also possible on all levels. Achieving these improvements is essential. A voluntary, rigorous, methodological and attentive approach requiring equal effort by all involved is required. The more firmly it is applied, the faster social security accounts can be rebalanced, and the better and more stable our social security system will become, not just in financial terms but with regards to the basic values of solidarity that are associated with the system.
The deficits and debt of the social security system: 2011 financial position and forecasts

Deficits in 2011 remain massive but are declining

After reaching an unprecedented level in 2010 (-€28 billion), or 1.4% of GDP, the deficit of the general scheme and the old-age solidarity fund (fonds de solidarité vieillesse, FSV) began to decline in 2011.

However, it remained particularly high: at -€20.9 billion (1% of GDP), it is more than double what it was in 2007-2008.

This improvement in the financial position observed in 2011 is primarily due to contributions from new resources and a resistant wage bill, although a certain degree of constraint in spending also contributed, including compliance with the national objective for health insurance expenditure (ONDAM). The new measures for revenue assigned to the general scheme and FSV (€7 billion) represent almost the entirety of the deficit reduction (€7.1 billion).

<table>
<thead>
<tr>
<th>Situation of general scheme and FSV accounts (in billions of euros)</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Health care</td>
</tr>
<tr>
<td>Work accidents</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Old-age</td>
</tr>
<tr>
<td>General scheme</td>
</tr>
<tr>
<td>FSV</td>
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<tr>
<td>RG + FSV</td>
</tr>
</tbody>
</table>

Source: accounts of general scheme and FSV
The deficits and debt of social security: 2011 financial position and forecasts

The majority of the work required to rebalance the social security accounts remains to be done:

- the deficit of the general scheme alone was exceptionally high for 2011 (-€17.4 billion or 0.9% of GDP). Two-thirds of this deficit is structural, which remains at the average rate it has been for the last decade;
- FSV remains a strong concern: its deficit (€3.5 billion) represented 19.7% of the net expenditures in 2011. Despite the contribution from new revenue, it will increase again in 2012 (to €4.1 billion according to latest estimates);
- certain schemes have also experienced structural imbalances: the pension scheme for local communities and hospitals (CNRACL), the old-age division for agricultural workers and the miners’ scheme.

Continual growth in social debt

Social security debt is mainly covered by CADES and the central agency for social security organisations (Agence Centrale des Organismes de Sécurité Sociale, ACOSS).

Despite CADES taking on €65.3 billion of accumulated deficits from previous years, the most it ever has, social security debt has started to increase again.

The transfer of part of these deficits (from old-age insurance and FSV) to CADES has already been planned for and financed, but this is not the case for the deficits of the health care and family divisions. In 2012 the latter should reach more than €9 billion, which has not been planned for.

More debt will need to be taken on immediately after the end of the 2012 tax year. This will require further growth in resources for CADES: if, as the Cour des Comptes previously recommended, it were raised by a rate corresponding to employee contributions towards the reimbursement of social security debt (contribution au remboursement de la dette sociale, CRDS), it should increase from 0.50% to 0.56%.

A situation that remains particularly concerning

Deficits that will remain high in 2012

The Cour des Comptes has updated the forecasts as of 1 September made at the start of July in its report on the financial position and forecast for public finances. Despite the new revenues that were approved over the summer, and despite it seeming that the ONDAM will be met again, the deficit of the general scheme should be, all other things remaining the same, €14.7 billion. This level is higher than planned by the social security finance law (loi de financement de la sécurité sociale, LFSS) for 2012 (€13.8 billion), and is just €2.7 billion lower than it was for 2011.

The FSV deficit should be kept to €4.1 billion, as planned by the LFSS. The effects of a degradation in
employment should be compensated for by more revenues from increasing the flat-rate contribution.

In the medium term, rebalancing requires new relief measures

Based on prudent economic assumptions and integrating the revenue measures approved during the summer of 2012, the Cour des Comptes has attempted to clarify the position of social security accounts in the medium term:

- the annual deficit of old-age insurance and FSV would continue after 2018 at a level of around €9 billion, far from the balanced budget that the retirement reforms aimed to achieve for by date;
- achieving an annual balance for health insurance (Assurance maladie, AM) without further expanding mandatory contributions depends on the effort to achieve the ONDAM: an annual growth rate of 2.4% would allow a return to balance in 2017, a growth rate of 2.7% would push it back to 2019;
- the annual deficit of the family division, which faces a progressive reduction in resources, partly due to the transfer of non-permanent resources should, all other things remaining equal, stabilise at around €2 billion.

In the absence of complementary relief measures, and in a scenario where the ONDAM increases by 2.7% per year, this would likely mean that by the end of the decade social security debt, within the scope of the general scheme and the FSV, would increase by around €60 billion over and above what the law has already planned to transfer to CADES.

Therefore, it is imperative that plans be implemented from 2013 for CADES to take on the 2012 general scheme deficit and to continually make a concerted, committed effort to cut spending.

Recommendations

1. Arrange that at the closure of the 2012 financial year CADES take on the 2012 health care and family division deficits from the general scheme by consequently increase the CRDS rate.
2. Increase control over social security spending, specifically for AM and increase receipts by acting primarily on social niches (recommendation reiterated).
3. Cease structural underfinancing of FSV (recommendation reiterated).
The national objective for health insurance expenditure in 2011

The national objective for health insurance expenditure in 2011 was set at 2.9% (compared to 3% in 2010), translating to a figure of €167.1 billion. This target corresponds to additional spending of €4.7 billion for 2011. For the second consecutive year, and for only the third time since it was created, spending has stayed within this target, and was even as much as €0.5 billion below the objective. This positive result has contributed to initiating the reduction in social security deficits observed in 2011.

Better and firmer management

The new ONDAM governance, established during 2010 was in full effect for all of 2011.

The role of the monitoring committee, composed of qualified persons, was enlarged, with the decision that it provides an additional two reports per year. Monitoring the ONDAM has been improved by establishing a group that tracks statistics. Lastly, a steering committee uses all of the information to make the necessary decisions. The desire for tight control over health insurance spending gives rise to a number of measures:

- funds were set aside as a precautionary measure at the start of the project (for a total of €530 billion);
- some funds, mainly concerning health establishments, have been cancelled (€338 million);
- some new measures were not been implemented (€420 billion), and as such revalorization of professional health care acts has been limited to the consulting of general practitioners;
- cost-saving measures passed during the creation of the ONDAM have been subjected to close monitoring (they represented a total sum of €2.35 billion or 98% of measures).
The national objective for health insurance expenditure in 2011

Despite this progress, there are some limitations regarding meeting ONDAM

The effect of a suitable design

ONDAM performance in 2011 has benefited from the overestimation of its base (anticipated expenditure for 2010). If various measures did not cancel out the effect, by maintaining an under-execution of the ONDAM in 2011 by the same amount, ONDAM growth would not have been limited to the objective of 2.9% but would have reached 3.2%. This underexecution compensated for the effects of the overestimation of expenses in 2010 by the same amount.

Additional elements to take into account

Work to identify and reassign all unregulated spending in the scope of the ONDAM should be carried out.

The report from the commission of social security accounts should report on the execution of the ONDAM over three years, in order to integrate the results of the conclusions of provisions initially accounted for.

An effort to maintain

The favourable effect associated with the overestimation of basic spending created the same risk for exceeding the ONDAM in 2012.

Without regulation, if there had been strict compliance with amount of forecast expenses, the effective growth rate would be 2.7% rather than 2.5% as set by the social security financing law.

The complete implementation of savings initially planned and very prudent management of frozen funds are thus required to effectively limit growth in ONDAM to 2.5% in 2012.
Recommendations

1. Provide a legal foundation for the steering committee and give it the priority of compliance with the total and growth rate for ONDAM.

2. Prepare a shared, transparent approach for preparing the ONDAM under the management of the monitoring committee.

3. Systematically evaluate the accuracy of forecasts made during preparation of the ONDAM.

3 Opinion of the Cour des Comptes on the balance sheets and asset table for 2011

The balance sheets and asset table for 2011, prepared by the ministry responsible for social security, are subject to approval by the Parliament as part of the draft social security financing law (PFLSS) for 2013. In accordance with the texts, the Cour des Comptes has checked their coherence.

*A coherent view of the results and of the national situation*

- balance sheets:
  The balance sheets delineate the revenues, expenditures and results of all social security schemes that belong to the divisions of the general scheme and FSV.
  The results of all basic obligatory schemes, the divisions of the general social security scheme and FSV given in the balance sheets are characterised by massive deficits, although they are below the historic levels of 2010:

<table>
<thead>
<tr>
<th>Results for social security schemes</th>
<th>2011 Deficit</th>
<th>2010 Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obligatory basic schemes</td>
<td>-€19.6 billion</td>
<td>-€25.7 billion</td>
</tr>
<tr>
<td>General scheme</td>
<td>-€17.4 billion</td>
<td>-€23.9 billion</td>
</tr>
<tr>
<td>FSV</td>
<td>-€3.5 billion</td>
<td>-€4.1 billion</td>
</tr>
</tbody>
</table>

*Source: ministry responsible for social security*
Opinion of the Cour des Comptes on the balance sheets and asset table for 2011

- asset table

The aim of this document is to improve information supplied to the Parliament about the financial position of entities covered by the social security financing law (different from the balance sheets, because they also include the social security debt reimbursement fund (CADES) and the pension reserve fund (fonds de réserve pour les retraites, FRR).

Taking the deficits into account, the overall debt of these entities, as laid out in the asset table, shows a new increase from the previous financial year.

The net financial liability of social security increased, amounting to €111 billion on 31 December 2011, or 5.5% of GDP, compared with €96 billion on 31 December 2010, or 4.9% of GDP. The increase in this liability over the previous year is mainly a result of the deficits in the divisions of the general scheme and the FSV for 2011, of which a large part is financed by CADES.

Financial statements of social security schemes remain unsatisfactory

The opinions expressed by the external auditors of the divisions and the collection activity of the general scheme (Cour des Comptes) and part of the other schemes and national social security organisations (commissaires aux comptes) indicate that the financial statements of this category of public administration have not yet achieved the required standard. In particular, the Cour des Comptes refuses to certify the accounts of the family and work accidents - occupational diseases (accidents de travail - maladies professionnelles, AT-MP) divisions of the general scheme; the accounts of self-employed workers scheme have once again been refused certification by their auditors.

On one hand, the reasons for this refusal and the reservations expressed by the external auditors have a direct affect on the level of results and on the evaluation of non-financial assets and liabilities that are respectively provided in the balance sheets and asset table.

To a lesser extent, the lack of reconciliation of certain inter-institutional transactions also suggests the existence of failings in the financial state of certain organisations.

Need to improve information provided to Parliament

The information provided to the Parliament regarding the financial situation of social security in the asset table is detailed and relevant. However, the quality of information provided by the balance sheets remains insufficient.

The annex to the draft social security financing law that aims to clarify the revenues and the expenditures indicated for the overall figure in the balance sheets:
- does not provide sufficient detail regarding what composes revenues and expenditures, which remain too grouped together;
- does not allow the understanding of withdrawals made by the minister for social security for revenues and expenditures which are part of accounting by the schemes;
- does not show the variations in revenues and expenditures (in amount and percentage) and does not provide any explanation for the causal factors.

Recommendations

8. Provide, within the framework of annex 4 of the draft social security financing law (projet de loi de financement de la Sécurité sociale, PLFSS), information on the composition and variation in revenues and expenditures taken into account in the balance sheets that have the same quality with that procured for annex 9 regarding the assets and liabilities detailed in the asset table (recommendation reiterated).

9. Ensure the homogeneity of accounting methods used for inter-institutional transactions involved within the scope of the balance sheets and asset table (recommendation reiterated).

10. In preparing balance sheets, eliminate internal transfers and cease contracting revenues and expenditures that exceed the regulatory framework established by the organic law relating to the organic social security financing law (loi organique relative aux lois de financement de la Sécurité sociale, LOLFSS) for preparing social security accounts. Failing this, describe, in annex 4 to the PLFSS, the impacts that this contracting has on the development of products and charges in relation to those effectively accounted for in the social security scheme (recommendation reiterated).
Certification of the accounts of the general social security scheme by the Cour des Comptes: an initial assessment

In order to assist the Parliament and the government in the control and application of the laws for financing social security, since 2006 the Cour des Comptes has verified the frequency, integrity and reliability of division accounts (healthcare, AT-MP, family and old-age) and the recovery effort performed by the general social security scheme. The Cour des Comptes sought to prepare an initial balance sheet for the certification of the general scheme accounts at the end of the second triennial audit cycle.

A major contribution to the quality of public accounts and an improvement in the management of social security

The work performed by the Cour des Comptes for this audit focuses on four issues: the risks of errors affecting operations performed and accounted for within the applicable legislation regarding deductions and benefits; the risks of errors affecting the accounting results recorded with regard to operations performed; the risks of over- or underestimating results; and the quality of the financial information.

In revealing the recognised or potential risks for errors in accounts, certification constitutes a powerful tool for improving the reliability of the accounts and, beyond this, progress on larger issues: correct application of decisions by the legislator and regulating authority; equal treatment and the actual quality of the service provided to people receiving support and those responsible for social security contributions; and making social security revenue and expenditure more secure.

Important progress

The four national organisations in the general scheme have committed to take action, some of them committing to significant action, aiming to reduce financial risks that the Cour des Comptes has noted are not sufficiently covered by internal audit mechanisms. Correct integration within the general accounting of information regarding
actions performed; incorrect attribution, attribution of an incorrect sum or the absence of attribution of benefits; and the failure to be exhaustive in collecting social security contributions.

The first six certifications resulted in improvements that were often notable, especially when the divisions committed to overhaul their applicable systems for internal control (which was the case for all), if they have additional accounting systems allowing them to support accounting entries (healthcare division) or whilst they have produced supporting elements that can partially compensate for the absence of correct accounting records (recovery effort).

Uneven progress

However, the tasks that have been undertaken did not all provide positive results and progress is uneven.

Not all bodies have adopted the certification process with the same determination. If it is used as a catalyst by ACOSS, and to a lesser degree by the national fund for workers’ health insurance (caisse nationale d’assurance maladie des travailleurs salariés, CNAMTS), the national fund for workers old-age insurance (caisse nationale de l’assurance vieillesse des travailleurs salariés, CNAVTS) has been slow in implementing the required work. For the family division, the reform of the internal control mechanism, the limitations of which caused the Cour des Comptes to refuse to certify the financial condition for the 2011 financial year, is a pre-requisite for any real progress.

In addition, within a large number of constituent organisations, certification is still too often considered to be a task that is only for accountants, although it primarily concerns directors and the departments they manage.

Current progress that has been made has not led to complete certification of the financial statements of the general scheme, that is to say that the Cour des Comptes has not been able to declare that it believes it has reasonable assurance that there is no significant error affecting results. As such, the Cour des Comptes has refused to certify the accounts of the family and AT-MP divisions and has noted reservations in certifying the accounts of the healthcare and old-age divisions as well as the recovery effort for the 2011 fiscal year.

The national organisations, as well as their governing authorities (the ministries responsible for social security and the budget), should thus make a more resolute effort to progressively increase reserves as recommended by the Cour des Comptes, by speeding up the implementation of changes required to make revenues and expenditures more secure.
Blockages in accounting to be resolved

The financial state of the general scheme continues to include omissions or faults which require ministerial decisions for correction:
- merging FSV with CNAVTS is required to provide a reliable picture of the deficit of the old age division, which is currently underestimated in relation to its resources (taking into account the structural deficit of the FSV, the old-age division does not record some products until the following financial year);
- the principle of registering accounts on an accrual basis is not fully respected: some products (social contributions of self-employed workers, taxes recovered by state services) are still recorded on a cash basis, the provisions for risks and expenditures are still recorded in an incomplete manner (which constitutes the main reason for refusing to certify the 2011 accounts for the AT-MP division) and the annexes to accounts do not mention the significant multi-year commitments given out in the form of benefits (particularly pensions);
- direct allocation of expenditures to its own funds and processing the financing of overtime pay (recording of revenues that are allocated to the following financial year) constitute other sources for errors affecting results.

Recommendations

For ministries responsible for social security and the budget

11. Define, through regulation, objectives and precise rules that can be enforced through internal control mechanisms within all constituent organisations and national funds in compliance with requirements for certification.

12. Integrate the FSV within the scope of the old-age division of the general scheme.
13. Remove factors blocking the processing accounts of certain operations or situations (social security contributions of self-employed workers, dedicated taxes, provisions for AT-MP disputes and multi-year commitments regarding social security benefits).
Financing social security through taxes

Separate from social security contributions and the general social contribution (contribution sociale généralisée, CSG), dedicated taxes (impôts et taxes affectés, ITAF) for social security amounted to €54 billion in 2011. They could reach nearly €60 billion in 2013 with the finance law amendment of 16 August 2012.

ITAF constitute the third pillar for financing social security

These taxes represent 12% of receipts for the social security basic schemes in 2011, after social security contributions (64%) and the CSG (16%) and includes around fifty different taxes. The ten main taxes constitute 85% of the total and the three largest, 61% (tax on income, taxes on tobacco and VAT on certain products).

Long limited to schemes for independent workers, ITAF increased between 2000-2010 to compensate for the increasing cost of reductions to social security contributions, reduce deficits and finance social security debt.

The general scheme is now the main beneficiary of ITAF (75% of total revenues), even if the schemes for self-employed workers and agricultural workers still benefit from significant fiscal resources. In terms of divisions, family and healthcare insurance are the greatest beneficiaries.
Financing of social security from taxes

Share of ITAF in the resources of all the basic schemes

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>All divisions</td>
<td>11.8</td>
</tr>
<tr>
<td>Healthcare</td>
<td>14.7</td>
</tr>
<tr>
<td>Old-age (except for ITAF to FSV)</td>
<td>8.4</td>
</tr>
<tr>
<td>Family</td>
<td>15.1</td>
</tr>
<tr>
<td>AT-MP</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Source: PLFSS data, Cour des Comptes calculations

Limited improvements in terms of diversifying the base and strength in contributions

ITAF is based on consumption (49% of 2011 total, €26.4 billion), far ahead of salary (26%, €14 billion), companies (19%, €10.2 billion) and capital (5%, €2.9 billion).

In the long term, the overall movement of the ITAF is similar to the other sources of finance for social security and is not, as such, in a position to speed up the balancing of social security accounts. The dynamics, however, vary by controlling schemes or divisions, to the detriment of the family and old-age agricultural workers divisions.

An unstable system that does not promote accountability

The incessant changes to ITAF over the last 10 years (distribution over the divisions, creation of new taxes) have not contributed to making finances attributed to the social sector secure. Furthermore, as opposed to the CSG and CRDS, the ITAF lack transparency for those who pay for and those who benefit from them. As can be seen from the companies’ social contribution (contribution sociale de solidarité sur les sociétés, C3S) designated for the self-employed workers scheme (regime social des independants, RSI), and since 2011 to the agricultural scheme (mutualité sociale agricole, MSA), the system negatively impacts accountability.
It is essential that this system be rapidly restructured

In the current situation where the movement to associate social protection with taxation will probably last for some time, this third pillar for financing now requires essential choices to be made so the methods for distribution and changes in its resources can be more clearly defined.

Without neglecting the priority of controlling spending, and with an approach of standardised obligatory contributions, different paths to achieving this should be examined.

Integrate the general reductions in expenditures in the social security tax schedule

This will show the net rates of the employer contribution, i.e., actually provided by companies, instead of the current higher gross figure, without taking into account various tax reliefs. The disconnection of the allocation of receipts for financing general relief on expenditures based on salaries from the growth in their cost, since 2011, favours integration.

Redefine and simplify ITAF for social security

A refocus of fiscal financing of the social security system around a smaller number of taxes could be carried out to increase transparency, with a growth in receipts that is at least equivalent to that obtained so far by all taxes within ITAF whilst maintaining a diversification of the bases in relation to being based on work.

This reduction in the number of taxes would go hand in hand with the restructuring of the ITAF around a main reference tax. Several options can be considered:

- an accrued sharing of the VAT revenue between the state and social security;
- reinforcing the environmental taxing set aside for social security;
- bringing ITAF and CSG closer together.

It would be suitable to re-examine the interest in continuing to ringfence taxes that have a basis that places the interests of social security against public health policies (consumption of tobacco and alcohol).

Organise a general discussion focusing on receipts from the financing law and the law for financing social security

This reform would allow an overall and more coherent approach to the sources for financing the state and social security. A single general discussion would be followed by an examination of the respective sections of the two texts relating to revenues, before passing on to an examination of expenditures.
Financing of social security from taxes

Recommendations

14. Examine the degree of taxation sought for each social security division (orientation).
15. Integrate general tax reliefs within the tables for employer social security contributions.
16. Redefine and simplify the tax contributions earmarked for social security as part of a consolidation of this third funding pillar.
17. Organise a joint examination of the revenues section of the draft law for finance (PLF) and for the draft social security financing law (PLFSS).
Reform of the SNCF and RATP pension schemes

Heavily subsidised schemes that remain far removed from the reforms of 1993 and 2003

Pension reforms carried out in 1993 for the general scheme then in 2003 for the civil service did not affect the pension scheme for the French national railway corporation (Société Nationale des Chemins de fer français, SNCF) (162,300 contributors) or the autonomous operator of Paris transport systems (Régie Autonome des Transports Parisiens, RATP) (43,600 contributors). However, faced with large demographic and financial challenges, these special schemes are mainly based on national solidarity through large subsidies from the State (in 2012, €3.2 billion for the SNCF and €0.55 billion for the RATP).

Rather than an alignment with the general scheme for private sector employees, the public authorities have finally opted, in 2007, for a progressive convergence with the civil service pension scheme. The principles and the rules of the 2010 reform have been applied to both schemes, but not the December 2011 reform of the civil service.

A partial and progressive harmonisation with the civil service

The convergence process involves three major points:

1) The rules for allocating pensions. The total duration of services and service improvements giving entitlement to a full-rate pension has been harmonised with the civil service by being platformed to 166 quarters. The principle of automatic retirement at the point of qualifying for retirement has been abolished. The regulations for duration of service and age for qualifying for pensions have been progressively extended (in 2022, age 52 for train crews or those working on the RATP underground and the SNCF drivers; age 57 for other SNCF staff and RATP staff working in workshops; and age 62 for RATP desk staff).

2) A re-evaluation of contribution rates.

3) Indexing of pensions is no longer based on company salary but on the French consumer price index (excluding tobacco), like other pension schemes.

The new reforms are however being implemented progressively and with a large time-lag (5-7 years) when
Reform of the SNCF and RATP pension schemes

compared to changes made to the pension scheme of the civil service.

Expensive considerations for companies

The desire of the public authorities to carry out the reform translated into numerous “additional measures” for employees, especially the SNCF.

Certain measures have been similar in the two companies in the form of additional grades, end of career measures and integrating bonuses into the pension.

Beyond this, companies have not adopted the same strategy: in the RATP, the measures have aimed to compensate for the reform’s effects on the pension levels (with full compensation for the mid-2008 to mid-2012 period) whilst in the SNCF, there has been a larger range of measures (around twenty in total): keeping senior staff within the company has been encouraged by salary increases, certain measures (“hard work bonuses”) have benefited many railroad workers.

The staff have, as such, benefited from significant advantages. For many of them this constitutes a real “bonus effect” that the workers did not feel during the pension scheme reform of 2003.

Even more than for the companies, the majority of these considerations will affect the two retirement funds since they will generate larger pensions.

Behavioural changes have been observed in the SNCF since 2009: employees retiring have pushed back their retirement by 0.3 year each year and the number of railroad workers retiring at “minimum retirement age” has fallen drastically.

Results that are largely symbolic

Forecast gains that are limited in the long-term

Depending on the agreed compensation measures, available data and retained assumptions on departing staff, the global balance sheet should be negative for this decade and probably slightly positive for the next twenty years.

For the years 2011-2020, the accumulated gain for the SNCF retirement fund will be equivalent to €4.1 billion (in 2010 euros), and on the order of €10.5 billion (2010 euros) for the next twenty years. For the RATP fund, this gain will be equivalent to €0.27 billion (2010 euros) between 2011-2020 and €1.4 billion (2010 euros) for the next twenty years.

These reforms however imply an additional cost for both entities. For the SNCF it will probably exceed the equivalent of €4.7 billion (2010 euros) for the present decade and €4.1 billion (2010 euros) for the following decade. For the RATP, the total cost of the reform shall be €0.2 billion for
Reform of the SNCF and RATP pension schemes

2011-2020 and €0.6 billion for the following decade.

Benefits are insufficient to significantly lighten the state’s contribution

The symbolic element of these reforms has been given priority over their contribution to balancing public finances. The state’s subsidising of these schemes shall remain high in the long-term: for the SNCF fund, while diminishing from 2016, it will be equivalent to around €2.2 billion (2010 euros) in 2030, and for the RATP fund it will continue to grow until 2019 and will be equivalent to €630 billion (2010 euros) in 2030.

A stability that cannot be guaranteed in the long term

In the medium term new steps will be required to ensure the sustainability of these two schemes. The responsibility of these reforms belongs as much to businesses as to public authorities, who should assume their task of generally steering these schemes in a manner that is much more coherent with the overall effort that will be required to guarantee the long term stability of the pension system as a whole and taking into account the aim of greater equality.

Recommendations

18. Supply the parliament with detailed and up to date annual information regarding the implementation of reforms to the SNCF and RATP schemes particularly including information about changes in retirement behaviour of staff as well as an estimation of the provisional balance of the schemes in the medium and long terms according to various assumptions.

19. Impose greater transparency on the SNCF and RATP by laying out plans for them to supply, in an annex to their annual balance sheets, a provisional assessment, following rigorous methodological criteria, of salary costs generated by the age pyramid and specific additional measures associated with reforms in the pension schemes of their staff.
The social security scheme for self-employed workers (RSI) covered close to 2.7 million contributors in 2011, 2 million pensioners and 3.9 million people benefiting from healthcare insurance services and receives €8.2 billion in contributions.

The creation of this scheme in 2005 aimed to simplify the management of social protection for artisans, tradespeople and self-employed professions and gain efficiency in the process, particularly with the transfer, in 2008, of the recovery of contributions to the organisation for recovering social security contributions (Union de Recouvrement des Cotisations de Sécurité Sociale et d’Allocations Familiales, URSSAF) and with the establishment of a single system for self-employed workers (interlocuteur social unique, ISU).

A total failure

Serious difficulties for those people covered

The installation of this system at the start of 2008 immediately caused major difficulties for those covered. For a large number of them, the creation of the ISU didn’t just mean numerous administrative difficulties, there was also a risk of them losing their rights. So the issuing of contributions was impacted by many errors and a part of the money collected was not able to be accounted for correctly, which lead to many contributors being subjected to the automatic taxation scheme. Those covered were not able to receive reimbursement for their healthcare because they didn’t have the required health card, sometimes for very long periods of time.

Significant financial consequences, mainly eluded

Due to the long-term softening of the function of recovering contributions, the Cour des Comptes estimates a loss of income over the first three years after establishing the ISU of between €1-1.5 billion at the end of 2010.

The financial effects of these malfunctions were hidden by the automatic balance of the RSI with the companies’ social security solidarity contribution (C3S), which lead to the social security debt being bloated because of the resulting deficit accrued from the old-age solidarity fund.
The social security scheme for self-employed workers and the system for collecting their contributions

Difficulties that have continued despite successive plans

Originally, concerns about the institutional balance were given priority over the realism required for the correct establishment of a new social security scheme. The transfer of the recovery was decided in the absence of a common vision of the funds concerned, and in a context of distrust between the actors of the social protection of self-employed individuals.

Furthermore, the complex nature of the dialogue between the different information systems has been largely hidden at the time of arbitration, and has not been considered as a risk factor.

Despite the commitment of RSI and ACOSS staff the problems dragged on for a long time because responses were too slow and gradual to deal with the design problems in the IT system. The lasting illusion that actors have the capacity to reduce the stocks of files accumulated and the delay in organising structured joint work just between the two bodies since 2010 have resulted in problems persisting.

Urgency in re-establishing the system for recovering contributions

Despite receipts partially catching up since 2011, the recovery function is yet to return to the position it was in before the establishment of the ISU. The amicable and forced recovery procedures are still not fully restored. The agreement on the objective and management of the RSI from February 2012 doesn’t envisage collection until mid-2014.

This re-establishment should be placed at the top of the list of priorities, especially for a scheme in structural deficit that depends on the related tax (C3S) for it to be balanced.

Since January 2001, the RSI and ACOSS have been simultaneously undertaking a particularly complex total restructuring of their IT systems.

Taking into consideration the size of the challenge and the significant possible impact on all of the collections performed by the URSSAF of a badly designed information system, it is imperative to perform a large and precise audit of the relevant solutions implemented and their capacity to build an interface with the RSI.

Without solid assurances, the question should be asked, once more, about the creation of a social security institution that is truly unique and situated within a single organisation, as opposed to the current ISU that is shared between the ACCOSS and the RSI.
The social security scheme for self-employed workers and the system for collecting their contributions

Recommendations

20. Prior to any reform of such a scale that is so complex, define a rigorous system for managing the project, particularly performing an exhaustive analysis of risks prior to any definitive decision, using a framework of monitoring and steering tools that match up to the challenge.

21. Ensure that the contributions not recovered are the subject of all due diligence to guarantee they are correctly identified and not simply cancel or disregard them, specify the scale of the delay in recovery and implement a strict monitoring system to reabsorb them in order to minimise losses.

22. Reinforce the strategic monitoring of tasks currently underway by the governing authorities, providing explanatory information, that is a broad as possible, including financial information, and considers the coordinated operational steering of the RSI and ACOSS on a national and regional level.

23. In order to guarantee a fast and complete recovery within the shortened deadlines, which is as robust as possible, perform a complete in depth audit of the future shared information system, allowing:
- the pertinence of the project to be ensured;
- the evaluation of risks of postponing the scheduled date from mid 2014, or failing to meet it, and consider all possible consequences;
- examine, precisely, all of the possible alternatives, including a study of a simplification of the regulatory framework of the ISU, or the re-examination of the shared responsibility currently in vigour.

24. Guarantee that the rights acquired by those covered in the name of contributions made are taken into account, exhaustively and swiftly, within the RSI information systems.
The establishment of ARS

A major structural reform

By setting up regional health boards (Agences Régionales de Santé, ARS) and assigning them regional management of the health care system in a broad-based approach encompassing prevention, the organisation of private-practice and hospital health care and the medico-social sector, the Act of 21 July 2009 innovated in three key areas: roles and responsibilities; regional administrative organisation; and the conduct of public policy.

The 26 ARS simplified the institutional landscape by combining a number of decentralised State services, health insurance services, and bodies such as the regional hospitalisation boards (Agences Régionale de l’Hospitalisation, ARH) and the regional public health groups (Groupements Régionaux de Santé Publique, GRSP), which already combined the State and health insurance services.

Rapid installation and controlled costs

Property considerations were an immediate concern for the directors, right from the preliminary planning phase, six months before the ARS were actually installed on 1 April 2010. It was decided, wherever possible, to have all of the staff work at a single site and to remain in the existing premises. The great majority of new premises were established in rented properties, which will have a financial impact for the ARS. Steps have been taken to reduce the floor space occupied, but these measures will have to be continued in coming years.

A special budget of €58 million was set aside for setting up the ARS. Known as an initial installation budget, it was financed by the health insurance system, the State and the residual ARH working capital fund. The total cost of setting up the ARS is estimated at €70 million. This includes the transfer allowances granted to the staff of the health insurance system and the cost of management within the ministry’s general secretariat.

The institutional position requires clarification

The goal is now for the ARS to achieve the objectives set for them and demonstrate their legitimacy with regard
The establishment of ARS

Summary of 2012 social security report
to the other national and local stakeholders. They face a number of difficulties in this respect.

National management remains very hierarchical

The national management council (Conseil National de Pilotage, CNP) set up to coordinate the network of ARS and ensure consistency in the national policies they have to apply has failed so far to initiate a national cross-cutting, strategic approach to health and health care issues.

Each central administrative body, such as the national health insurance fund for salaried workers (Caisse Nationale de l’Assurance Maladie des Travailleurs Salariés, CNAMTS), continues to deal directly with the ARS or the organisations in their network, in a rather centralizing approach with no lateral interaction.

Uneasy collaboration with the health insurance system

Collaboration between the ARS and the health insurance system, which is necessary for taking risk management measures, was long marked by a degree of resistance on the part of the CNAMTS as it strived to maintain some of its prerogatives. It should improve now that the ARS have been authorised to use the health insurance system’s legal tools and information systems.

Complicated relations with the prefects

Relations between the ARS, which have taken over some of the areas of responsibility formerly handled by the decentralised State services (the regional health and welfare department [Direction régionale des affaires sanitaires et sociales, DRASS] and the departmental health and welfare department [Direction départementale des affaires sanitaires et sociales, DDASS]), and the prefects continue to be complicated. The latter have kept their royal powers in matters concerning public health monitoring, safety and health regulations; the ARS services are at their disposal to help carry out these roles and responsibilities. This new distribution of roles in the wake of the State’s reorganisation at regional level created tension. The agreements signed between the ARS and the departmental prefects to define how their cooperation will work in practice, and the joint instructions issued by the general secretaries of the French ministry of the interior and the ministry in charge of welfare should facilitate the partnership.

Operating resources need to be modernised

If the ARS are to successfully fulfil their roles and responsibilities, they must also be able to take several other measures.
Simplify workforce management and adjust skills

The ARS face difficulties resulting from the diverse statuses of their staff, which are a carry-over from the structures that merged to form the ARS, and the mismatch between staff profiles and their tasks. The juxtaposition of private-sector statuses, for staff from the health insurance system, and public-sector statuses, for officers from State services, results in disparate working conditions and compensation. The role of the joint administrative committees in managing civil servants also limits the powers of the director general of the ARS. Lastly, the multitude of statuses makes the system difficult to manage.

Invest in information systems

The ARS inherited an abundance of information systems from the previous organisations, and the systems are not compatible. But if the ARS are to successfully carry out their tasks, it is absolutely essential to upgrade these systems. A national master plan was drawn up in 2011 to specify which ARS projects should take priority and what sort of governance should be set up in terms of national management of the information systems. It will only be implemented, though, if the necessary budgets are allocated to this priority.

Give the ARS the financial resources they need to do the job

Work is still under way on giving the ARS the resources they need to conduct a regional health policy. The regional operations fund (Fonds d’intervention régional, FIR) established by the French social security finance act (Loi de financement de la sécurité sociale, LFSS) for 2012 - and which sets out to remove the barriers between funding for private-practice health care, hospitals and medico-social facilities - is designed to give the ARS greater leeway for allocating certain finances. The reach and effectiveness of this new tool will depend on how it is implemented.
The establishment of ARS

Recommendations

25. Set up a national management system that allows ARS the autonomy they need to carry out their tasks. This implies:
- defining a decentralisation procedure whereby central administrative bodies give the ARS greater responsibility;
- restoring the CNP’s strategic orientation function.

26. Draw up the next agreements on targets and resources (contrats d’objectifs et de moyens, CPOM) with each ARS. The agreements should:
- show how these targets fit in with the regional health project’s targets;
- set targets for internal efficiency or productivity gains that will keep the ARS on track for the multi-year budget road map.

27. Simplify ARS human resources management by:
- allowing them to recruit more contract staff;
- bringing the situation of private-law officers into line with the general scheme’s collective bargaining agreements (drawn up with the French federation of national social security funds: Union des caisses nationales de sécurité sociale, UCANSS);
- laying down procedures for transferring civil servants within the same ARS.

28. Implement the ARS information system master plan and make it a priority within the ministry.

29. Increase the FIR in order to give the ARS greater leeway to take financial measures.
The role of the Ordre National des Médecins in organising health care and upholding medical ethics

Oversight of the profession is adequate on the whole

One important role of the French national board of medical doctors (Ordre National des Médecins, ONM) is to maintain an up-to-date list of medical doctors fulfilling the required legal and ethical conditions to practise. This role enables the ONM to regulate professional practice and publish an annual study of medical demographics.

Legal changes such as the European principle of automatically recognising medical degrees and registering qualifications have broadened the ONM’s sphere of responsibility. The ONM plays an active role in recognising qualifications and assessing the validity of the documentary proofs submitted for the purpose.

The ONM was slow to become involved, but now maintains a list of all civil doctors in the shared register of health care professionals that was established. The register has simplified the formalities for doctors and improved communication between the stakeholders (the ONM, the ARS and the health insurance system). The ONM has become their sole identification authority.

A smaller contribution now to round-the-clock health care services

Round-the-clock health care services organise a system of on-call practitioners to meet unscheduled demand for health care at night and on weekends and public holidays. Up until 2003, it relied on compulsory on-call duties supervised by the ONM. Now the ONM acts as a facilitator and expert, certifying volunteers’ capacity to assume on-call duties and drawing up a list of exempted doctors and a list of doctors who can assume on-call duties. The Cour des Comptes has noted that the degree of involvement of councils and doctors varies with the department, and that it is increasingly difficult to provide round-the-clock health care in rural areas.
Insufficient adjustment to the regional reorganisation of the health care system

The ONM is organised into 127 national, regional and departmental councils. In 2007, it was decided to broaden the responsibilities of the regional councils in view of the regional reorganisation of the health care system led by the ARS. However, practical application of the reform is still patchy.

Controls on the upholding of medical ethics do not go far enough

Ethics oversight underpins the ONM’s very existence. Its application is essential in the interest of not only the profession but also patients.

Numerous difficulties with handling complaints

Responsibility for enforcing the code of ethics lies with the disciplinary bodies of the ONM’s regional councils, most of whose members are drawn from the medical profession, then with the ONM’s appeals board. Complaint processing times are sometimes long, even though the number of cases registered is stable at around 1,300 a year. The severity of the sanctions varies by region. Very often, sanctions are accompanied by a total or partial reprieve. ARS almost never refer complaints to the social security divisions that judge fraud or misuse cases brought against practitioners, and the health insurance system seldom does so (200 cases are registered each year).

Ineffective controls of the use of tact and restraint in setting fees

The principle of tact and restraint refers to the way doctors go about charging higher than standard fees, and how these fee surcharges are adjusted to each patient’s financial means. The national council issues periodical reminders of this principle, but few cases are ever referred to the ONM (around 15 convictions for misuse and fee surcharges a year) and the sanctions are very modest (generally a reprimand or a warning).

This passivity is not really offset by the other three measures in use at the same time: the possibility of direct sanctions applied by the health insurance funds, criminal proceedings, and sanctions under Annex XXII of the medical agreement, renewed in July 2011. Although the volume of fee surcharges is steadily growing, few sanctions are applied and they are generally not very harsh. The fact that there are a variety of procedures available is by no means a guarantee of effectiveness.
More should be done to prevent conflicts of interest

The ONM takes an active role in preventing conflicts of interest:
- by overseeing work contracts signed by doctors on its register, and which doctors are required to send to the departmental council responsible for them. It checks that each situation complies with the code of ethics (the duty of secrecy, in particular). It also checks professional independence and that there is no productivity clause in the doctor’s compensation. The ONM plans to step up national oversight of this role shortly;
- by controlling the relations between doctors and industry. There is a blanket ban on medical professions receiving direct or indirect advantages in kind or in cash from the pharmaceutical industry, except for research, evaluation or hospitality agreements. The ONM issues opinions on some 80,000 agreements each year, but the conditions still vary with the department and the ONM has undertaken to harmonise them. Its powers were reinforced by law in December 2011, though not all of its proposals were adopted by the legislator.

The scant cooperation between the ONM and the French directorate for competition, consumer rights, and protection against fraud (Direction Générale de la Concurrence, de la Consommation et de la Répression des Fraudes, DGCRF) limits their respective efficiency and calls for the conclusion and application of measures to ensure stricter enforcement of the so-called “no-gifts” law. The State should also stipulate that any ONM opinion recommending against an agreement be considered obligatory.
The role of the Ordre National des Médecins in organising health care and upholding medical ethics

Recommendations

30. Modernise the ONM’s regional organisation and adapt it to regional management of the health care system by gradually transferring the roles and responsibilities fulfilled up until now at departmental level to the regional councils.

31. Clarify and more effectively coordinate the various measures used to check the use of tact and restraint in setting fees.

32. Give the ONM’s council greater powers to control doctors’ relations with industry by making the council’s opinion on a contract or agreement - whatever its purpose - obligatory. In the event of a negative opinion, the contract or agreement may not be carried out, on pain of sanction.

33. Establish a protocol for exchanging information between the ONM and the DGCCRF, for greater transparency and tighter control of relations between doctors and industry, if necessary by using a regulatory provision.
The health insurance system’s payment of social security contributions for self-employed health care professionals

A cost of €2.2 billion for the health insurance system in 2011

For many years, this measure was confined to sickness insurance contributions for Sector 1 doctors (i.e. doctors who charge the standard fee set by the social security). It was subsequently extended to include other social security contributions and other self-employed health care professionals (dental surgeons, midwives and paramedics).

This payment on behalf of the health care professionals contributes substantially to their income: for Sector 1 doctors, it represented 18% of general practitioners’ income in 2008 and nearly 16% of specialists’ income.

The payment covers practically the entire health insurance contribution and a large proportion of the personal contribution for family allowances and additional old-age coverage.

Over the years, the list of contributions paid and professionals concerned has grown longer with each round of talks between the health insurance system and representatives of the different professions.

Since 2004, nothing stands in the way of the health insurance system also paying the contributions of Sector 2 doctors (who set their own fees), even though these doctors are free to choose a significantly more advantageous affiliation, in terms of contributions, to the social security scheme for self-employed professionals (Régime social des indépendants, RSI).

Despite their high cost for the health insurance system, these measures are not very visible and their purpose is not very clear for either the beneficiaries or the insured.

A system with no real benefit in return

Initially, the aim of the system was to encourage doctors to enter into a contractual relationship with the health insurance system so that it could impose certain limits on their freedom to set their own fees.

As it happens, though, this social advantage plays only a very marginal role:
The health insurance system’s payment of social security contributions for self-employed health care professionals

- in the decision of an overwhelming majority of doctors to sign an agreement with the system, which is mainly motivated by the desire to see patients financially able to consult a doctor because the health insurance system reimburses their expenses;
- in doctors’ choice between Sector 1 and Sector 2.

The financial benefit that Sector 2 practitioners derive from being able to charge higher fees far outweighs the outlay generated by having to pay their own contributions. When the health insurance system assumes the cost of medical practitioners’ contributions, this is not used to promote a policy of curbing fee surcharges, which are applied more and more frequently by these professions on a growing number of medical procedures. The health insurance system has had no influence whatsoever on the dramatic increase in fee surcharges observed in recent years among doctors and dental surgeons.

Refocus the system on the objectives of easy, fair access to health care

A tool for distributing health care professionals

An adjustment to all of the social security advantages enjoyed by doctors, including those already established, based on whether they practise in areas with a high or a low proportion of doctors, could be applied to all of the professions where the geographical imbalances are such that they impede equal access to health care. The health insurance system’s financial contribution would once more have a reason to be clearly identified and recognised for both professionals and the insured.

A possible contribution to regulating fee surcharges

The health insurance system’s financial contribution appears unjustified when, in practice, health professionals enjoy considerable freedom when it comes to their fees, mainly through fee surcharges.

The conventional social security advantages could be reserved for categories of procedures to which social security fees can really be applied. The government should rapidly carry out a stringent cost-benefit analysis of the recent reform of the coordination option, which establishes the extension of the health insurance system’s payment of contributions to Sector 2 practitioners.

Unless such advances can be achieved, the question will have to be raised of whether these advantages, which bring nothing in return, should be maintained.

At the very least, an effort should be made to lower their cost. It would be logical to cap the benefit per professional. This could be done by capping the basis used for calculating the benefit, and/or applying some form of sliding scale (as is already the case for family contributions).
The health insurance system’s payment of social security contributions for self-employed health care professionals

Recommendations

- 34. Reform the system in order to facilitate access to health care:
   - by adjusting the amount of contributions paid on professionals’ behalf according to the density of health care professionals in a given area;
   - by excluding income derived from categories of procedures where fee surcharges are almost systematically charged;
   - or by making them subject to compliance with surcharge ceilings.

Failing this, stop paying contributions on practitioners’ behalf or, at the very least, cap the amount per health care professional.

- 35. Make it mandatory for all contracted health care professionals to be affiliated with the scheme for contracted practitioners and paramedics (praticiens et auxiliaires médicaux conventionnés, PAMC). This means that, unlike Sector 2 practitioners, they would no longer to be free to join the RSI scheme.

- 36. Make these payments more visible, like the employer contributions shown on pay slips, by showing their cost in an annual statement sent to professionals by the health insurance system.

- 37. Regarding the rules specific to the PAMC scheme:
   - bring them into line with the rules that apply to other social security contributions as concerns the period of insurance cover and the basis used for calculation;
   - remove the ceiling from this basis in the case of income derived from non-reimbursable procedures;
   - make it compulsory to show all of the procedures performed and the professional fees received on the medical claim form.
Patient transport costs paid by the health insurance system

A dynamic expenditure of €3.5 billion a year

Depending on patients’ state of health, they can be transported by ambulance or by professional seated patient transport (transports assis professionnalisés, TAP), i.e. in a taxi that has signed an agreement with the health insurance system or in a patient transport car (véhicule sanitaire léger; VSL). The health insurance system pays the cost of patient transport, in full or partially. In 2010, these costs amounted to a total of €3.5 billion. They are increasing steeply and at a faster pace than the other health care costs. They now represent 50% of the reimbursements of general practitioner consultations. A sizeable proportion of them could be avoided, though, without deteriorating access to health care.

Poorly documented growth factors

Transport usage has a number of causes: the population’s state of health, the organisation of health care services, doctors’ attitudes to prescribing patient transport, and the range of available transport services. No in-depth study has been carried out to understand how these factors are linked, or local differences, even though this is a vital step towards controlling this expenditure.

Tighten controls on transport prescriptions

An initiative to curb prescriptions partially implemented

Formal prescription guidelines define the conditions requiring patient transport. However insufficient steps are taken to ensure compliance, particularly regarding the need for ambulance transport, which is more expensive, or documentary evidence that the transport is linked to a long-term condition, in which case the transport costs are fully reimbursed. A more stringent application of the guidelines would limit the amount of unjustified expenses, which are estimated at nearly €220 million nationally.

Moreover, the rule stating that transport costs are reimbursed on the basis of the distance from the patient’s pick-up point to the nearest suitable facility - aimed at keeping transport to a minimum, based on the range of
available health care facilities - is not strictly applied.

Prescribers not very aware of their responsibilities

The bulk of efforts to control the demand for patient transport has focused on private-practice doctors. The heaviest prescribers of transport have been obliged to seek prior approval, under a procedure introduced by the French Health Insurance Act of 2004. However this measure concerned only a small number of prescribers (a total of 76 in 2008) and applies only to doctors in private practice.

But it is the doctors in health care facilities who prescribe the most transport (53% of expenditure) and no real measure was taken to ensure tighter control of transport prescribed in hospital until 2010. The budget act for 2010 provided for contracts to be drawn up between the ARS, the local health insurance bodies and the hospitals, whose transport expenses have increased sharply, but the tools that would allow these contracts to be implemented have not been brought in.

Apply tighter quota restrictions on the supply of transport

Quota restrictions on the supply side are the most effective means of controlling this expenditure, but the measures introduced are ineffective.

The Cour des Comptes has noted that there are considerably more ambulances and patient transport cars than necessary: in over two-thirds of French departments, the number of vehicles exceeds the ceiling set by a 1995 regulation. Moreover, the quota restrictions can be by-passed by using contracted taxis.

The organisation and fee structure of the on-call ambulance system - which responds to requests from the emergency medical services (Service d’Aide Médicale Urgente, SAMU) on Saturdays, Sundays and week nights - has two major flaws. There is no financial incentive for the transport company to respond to the SAMU’s requests, and in some sectors, the number of patients transported during the on-call period does not warrant having two on-call systems, one provided by patient-transport companies and the other by the departmental fire and emergency response service (Service départemental d’incendie et de secours, SDIS). Reforming this on-call system could save nearly €100 million a year.

Fix up management shortcomings

At the moment, the health insurance system has little interaction with taxis and no reliable statistics on the sector. Additionally, there is no common pricing system between VSL and taxis for the same service, even though patient transport companies often have taxis as well as VSL.
Lastly, local management is poorly distributed between the ARS and the primary health insurance funds (Caisses primaires d’assurance maladie, CPAM). The director general of the ARS accredits the patient transport companies and grants authorisations to commission vehicles (ambulances and VSL). Each patient transport company signs the national agreement established between the health insurance system and the professional bodies, through the CPAM. The ARS have not compiled a national register of accreditations and patient transport vehicles, and they do not have access to the register compiled by the health insurance system.

**Run more stringent invoice checks and audits**

Patient transport companies and taxis offer the possibility of using the third-party payer system, and send their invoices directly to the local health insurance funds. However the funds very seldom check for the supporting documents and essential verifications are not carried out, with the result that the health insurance system sometimes makes overpayments.

An amount of €120 million could be saved by running tighter checks on how the invoices - and especially the mileage figures - are calculated.

The anti-fraud plans drawn up at national level and applied by the CPAM are far from yielding an accurate assessment of the level of fraud. The national review shows that a large part of the audits result in recovering overpayments, without any penalties being applied. For the companies concerned, therefore, the audits are not dissuasive at all.

In all, at least €450 million of the €3.5 billion paid out in refunds could be saved without deteriorating access to health care.

**Main ways to save money without deteriorating access to health care**

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<thead>
<tr>
<th>Description</th>
<th>Savings (€m)</th>
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<tbody>
<tr>
<td>Enforce the prescription guidelines</td>
<td>220</td>
</tr>
<tr>
<td>Reform on-call ambulance services</td>
<td>100</td>
</tr>
<tr>
<td>Assess invoiced amounts more accurately</td>
<td>120</td>
</tr>
<tr>
<td>Total</td>
<td>440</td>
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</tbody>
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*Source: Cour des Comptes calculations based on data from the CNAMTS and the Directorate General of Care Provision (Direction générale de l’offre de soins, DGOS)*
Recommendations

38. Analyse supply and demand in patient transport services in order to define a cost-cutting action plan with specific target figures. This analysis should be carried out without delay in every department, under the responsibility of the ARS, using data from the health insurance system.

39. Step up coordination between the ARS and the health insurance funds for accrediting, signing agreements with and controlling patient transport companies and taxis.

40. Introduce a dual departmental ceiling for patient transport services: one for ambulances and the other for VSL and contracted taxis.

41. Define a common, verifiable pricing structure for VSL and taxis, and lower the percentage of overpayments by effectively checking invoices.

42. Systematically apply anti-fraud measures and revise the range of penalties applied for improper or fraudulent invoicing to make them dissuasive.

43. Revise the conditions in which applications for prior consent are necessary, reactivate the rule of the nearest health care facility, including for dialysis, chemotherapy and radiotherapy, and have the health insurance system’s medical service check compliance with the prescription guidelines.

44. Consider transferring the transport costs hospitals initiate to their budget so that the prescription, organisation and public-procurement management of this expenditure is subject to budget constraints.

45. Carry out an in-depth evaluation of the ambulance on-call system with a view to reorganising its organisation.
Aftercare and rehabilitation

Every year, 900,000 patients enter aftercare and rehabilitation units (services de soins de suite et de réadaptation, SSR) for rehabilitation or convalescent care. This sector, which can cater for 106,000 patients and outpatients, lies at the crossroads of general practice, short-term hospitalisation, and welfare and medico-welfare care. The ensuing health insurance expenditure is expected to amount to €7.8 billion in 2012.

A sector marked by diversity

The very diverse nature of the sector is mainly the result of the type of care given. The 2008 reform that made the sector more medical and technical has not eliminated all of the overlapping between specialisations, and patients - especially elderly patients - are not always referred to the most appropriate specialist.

Depending on their status, SSR facilities have different management systems. Private facilities, whether they are non-profit (Etablissements de santé privés d’intérêt collectif, ESPIC) or for-profit (clinics), represent just over half of all facilities and 60% of the care dispensed. They are more likely than public facilities to be specialised in one or two types of care, such as orthopedic rehabilitation or respiratory disease. Public facilities tend to be more general in nature. The bulk of their activity derives from prescriptions from short-term hospitalisation units. It is difficult to tell, though, what category of facility cares for patients with more severe or more complex disorders.

Public and non-profit facilities financed by an overall allotment have an average daily cost that is 40% higher than clinics financed by a per-diem rate. This latter pricing system tends to encourage an increase in activity and explains, in part, the higher occupancy rate in clinics, even if other factors have to be taken into account to explain these lower costs, such as fewer medical staff, less dependent patients, and, to some extent at least, better organised facilities.

No real needs analysis behind the supply side

In eight years, patient/outpatient capacity has increased by 12.3%, with the for-profit private sector proving the most dynamic.

However there was no precise management behind this expansion. There was limited assessment of the qualitative and quantitative
Aftercare and rehabilitation

requirements. The assessment focused mainly on regional differences, with no national overview, and insufficient attention was given to a pathology-based approach. No provisions were made for distributing locally-developed patient-referral aid tools such as Trajectoire, for example, nationwide.

The supervisory authority did not realise how fast expenditure was growing until 2010, long after the applications for consent imposed on health care facilities by the 2008 reform had been processed.

As a result, there were no means for enforcing regulation for a long time, and even now regulation is not perfect. The budget act for 2011 established a prior consent mechanism for some procedures, but it has only limited scope for the moment. The accompanying creation of a specific sub-objective for SSR activities, as part of the annual projected health insurance expenditure (ONDAM) should help more effectively regulate expenditure. A study of inappropriate stays in short-term hospitalisation units has begun to bring the very necessity of creating SSR beds under critical examination. But, for want of a similar study on inappropriate stays in SSR units, consideration of the issue remains incomplete.

Give priority to streamlining the health care path

For the SSR activity to operate efficiently, it is fundamentally important for the health care and medico-welfare sectors to be properly coordinated in the patient's health care path.

But patients continue to experience obstructions, delays and inappropriate referrals both when they enter and when they leave SSR. Estimates put the number of inappropriate admissions at between 10% and 20% of SSR beds. On top of the inappropriate admissions, there is an increase in the number of early admissions of non-stabilised patients who in fact require continued acute care. It is even more problematic when patients leave the facilities, especially when they cannot go home.

As a result, SSR activities are doubly dependent: on upstream hospital care and on downstream medico-welfare care. This inevitably has an effect on the problem of their financing.
A sector looking for appropriate financing

Current financing arrangements raise the problem of fairness, since the differences in budget allotments or rates between facilities bear no connection with the complexity of the cases handled.

However, for some years now there have been plans for a rapid changeover to an activity-based rate structure revolving around a medium-term stay. This implies the existence of stakeholders capable of making independent decisions and equipped with the means to manage their activity. SSR, especially in the public sector, has not attained this degree of maturity.

Quite apart from the technical problems, much has yet to be done in the way of design and testing in order to develop an appropriate system of financing. Before this can be achieved, patients’ path between the various links in the health care chain must be made smoother and easier.
Recommendations

46. Evaluate the number of inappropriate stays in SSR at national level, using a consistent methodology. Use the results to deduce the actual requirements for SSR care, based on the pathologies to be treated.

47. Based on these figures, set precise objectives for the ARS in order to solve the difficulties of referring patients whose condition allows them to leave SSR. Rapidly bring in tools (e.g. Trajectoire) that will provide clear operational data on the availability of beds and places:
   - for patients transferring from medicine-surgery-obstetrics (Médecine-Chirurgie-Obstétrique, MCO) to SSR, on the one hand;
   - for patients transferring from SSR to downstream medico-welfare services on the other.

48. Before starting to reform the financing arrangements, carry out tests to ensure that the reform will in fact rationalise financing without generating additional problems in patients’ health care path. In the meantime, improve the operational aspects of adjusting the annual financing allotment (Dotation annuelle de financement, DAF) and the per-diem rate according to the complexity of the treatments dispensed.
The hospital certification procedure is aimed at contributing to the continuous improvement of the quality and safety of the health care delivered to patients. Using indicators, criteria and standard reference documents, it assesses the quality of a health care facility or its services. The French National Authority for Health (Haute autorité de santé, HAS) has been responsible for this task since 2004. In 2010, the cost was estimated at €22.4 million (excluding the cost for the facilities).

Efforts to simplify and medicalise the procedure should be continued

The French procedure is loosely based on examples in other countries. It differs from them in that it is compulsory, it is implemented by a single national body, and its results have no legal or financial consequences for the facilities.

Since 1996, virtually all facilities have completed two certification procedures and begun a third one.

The procedure has been gradually medicalised, simplified and made more understandable. For instance, improving the medical service provided to patients has been written into the objectives, and indicators have been introduced to measure health care quality. Two new tools would further simplify the procedure: risk mapping for each facility, based on the results of earlier certification cycles, and upgrading hospital information systems so that indicators were automatically filled in.

New room for improvement

With successive procedures, we observe a risk that certification will become less effective. This should prompt the HAS to improve its approach.

Specify the scope of certification

Each facility is currently covered by a single certification procedure, even if its activity is carried out at more than one site. As a result, sites of different quality are regarded as one, and differences arise in certification requirements depending on the size of the facilities. In large groups, such as the public hospital systems of the cities of Paris and Marseille (respectively Assistance publique – Hôpitaux de Paris, AP-HP and Assistance publique – Hôpitaux de Marseille, AP-HM),
Certification of hospitals by the French National Authority for Health

Individual site inspections could be organised in addition to inspections of each legal entity.

**Improve measurement of the impact of certification**

Alongside the third-party studies on how certification affects the facilities involved, the HAS could analyse the data it has collected itself.

**Detect risk areas**

The HAS is not systematically informed of the serious undesirable events that occur in some units, even though this could allow it to compare the problems observed with the certification reports, and learn lessons for the future.

**Emphasise the medical aspects of certification**

The quality approach introduced by certification also involves periodically evaluating the doctors and medical teams - which is currently a blind spot in the procedure - and certifying a given facility by coherent groups of activities deemed to be risky.

**Inform the public of the outcome of certification**

The HAS website publishes all certification reports, but it is difficult for a non-specialist to interpret the mass of data presented there.

The HAS should publish an annual overall certification report by category of facilities (public, for-profit and non-profit private), showing the risk areas it detected.

**Take the certification results into account in the facilities’ agreements on targets and resources.**

Currently there is no outside incentive for facilities to progress towards “full” certification, with no reservations or recommendations.

There are a number of possible avenues for reform:
- establish closer links between the procedure in which facilities sign contracts with the ARS and the certification procedure by the HAS;
- write into the agreements on targets and resources signed by the ARS and the State targets corresponding to the measures necessary for applying the recommendations and removing the reservations expressed during the certification procedure;
- or refuse to grant permission for high-risk treatments if a facility is not certified, or if the certification decision has been suspended because of major reservations.
Certification of hospitals by the French National Authority for Health

Recommendations

49. Carry out impact studies by cycle, by category of facility and by region, and use the lessons learnt to improve the certification procedure and build facilities’ knowledge.

50. Accentuate the medicalisation of the approach by systematically studying discrepancies between the certification decisions and serious undesirable events brought to the knowledge of the HAS, by developing the accreditation of doctors and medical teams, by promoting staff training courses on best practices, and by testing the certification of coordinated groups of activities.

51. Include the certification results in the contracts negotiated by the ARS with the facilities in order to monitor application of the HAS recommendations, remove reservations, and derive financial consequences if necessary.
Old-age coverage for the poorest people

Nearly one million people over the age of 64 were living below the poverty line in 2009. This is over 10% of this age bracket. The bulk of their resources comes from the social protection system: pension schemes and national solidarity in the form of the basic old age pension.

The basic old age pension still plays a major role

The basic old age pension, which was created in 1956, covers 940,000 people, including beneficiaries’ spouses and beneficiaries living abroad (close to 240,000 people). Over 55% of the beneficiaries of the basic old age pension are women. One quarter of them are over the age of 80.

This benefit, now known as the solidarity benefit for the elderly (Allocation de solidarité aux personnes âgées, ASPA), can be paid to anyone aged 65 or over, providing the person applies for it. It brings its beneficiaries’ total resources up to €777.16 a month for a single person or €1,206.39 for a couple.

Despite the end of the 60-year rise of the basic and complementary pension schemes, and the introduction of minimum pensions by the main retirement schemes, the basic old age pension is still a key tool for keeping the elderly out of poverty.

In 2011, the basic old age pension represented a total expenditure of €3 billion, financed by the old-age solidarity fund (FSV).

The need for more active measures to inform potential beneficiaries

For the system to play its role more effectively, more active measures have to be taken, earlier, to inform eligible people.

The fact that the 2007-2012 revalorisation plan did not have any significant effect on the number of beneficiaries suggests that a large part of the new potential beneficiaries did not spontaneously apply for the benefit.

Part of this sector of the population is still unknown and will remain unknown unless the management bodies organise canvassing campaigns.

Expenditure could remain dynamic

The basic old age pension was long considered to be bound for gradual extinction, but the decline in beneficiary numbers came to a halt in 2007.
Old-age coverage for the poorest people

Two factors may even see its cost increase. The first of these is the recent drop in the average resources of new beneficiaries prior to the benefit. (The average value of the basic pensions assessed in the general scheme for new beneficiaries of the basic old age pension who have not worked the full number of years has gone from €314 a month in 2006 to €294 a month in 2010 in 2006 constant euros.) The second factor is that generations with more discontinuous careers are reaching retirement age.

Regulation mechanisms have limited effectiveness

There are few tools available for containing this mounting expenditure. The new rules applicable since 2007 are admittedly more restrictive, but they apply only to new beneficiaries. In addition, benefits paid outside France before 2006 continue to be paid, though the legal framework is ambiguous.

The possible adjustments have a limited scope:
- removing the ceiling on the recovery of benefits on an estate seems justified, but would probably have only very modest financial effects;
- better coordination with the age-related measures in the pensions reform could also be considered. This would consist in pushing back the minimum age for receiving the basic old age pension, in the same way as for the full old age pension.

Clear, sustainable financing for the system has become a necessity

Since the legislator chose to tighten the requirements for granting the basic old age pension only for newcomers, it is essential to find a way to provide clear, sustainable financing.

It is also important to give the FSV lasting resources to cover the deficit, which reached €3.45 billion in 2011 (the ASPA is largely responsible for this imbalance).

Without these resources, this system of national solidarity will continue to be financed by the social security debt, i.e. by the generations to come.
Recommendations

52. Provide clear, stable financing to cover the cost of the basic old age pension by raising the resources allocated to the FSV.

53. Clarify the legal grounds for continuing to pay the L. 814-2 increase abroad.

54. Harmonise the procedures for controls and their monitoring between the different bodies managing the basic old age pension by aligning them on best practices.

55. Remove the ceiling on the value of the ASPA benefits that can be recovered from an estate, and make it routine practice to recover from an estate the future payments of all level one benefits.

56. Push back the common law minimum age for receiving the ASPA at the same rate as the age for cancelling the discount in the general scheme.

57. Use suitable means of informing the public:
   - organise a meeting for 65-year-olds at the National Old Age Insurance Fund (Caisse nationale de l’assurance vieillesse, CNAV) and the Central Agricultural Mutual Insurance Fund (Caisse Centrale de la Mutualité Sociale Agricole, CCMSA) to repeat information about the ASPA given when the pension was assessed, or step up partnership initiatives between the pension funds and local authorities’ welfare services;
   - conduct an active canvassing campaign addressed at retired people who might have become eligible for the basic old age pension following the recent revalorisation plan.
Although there are still some individual situations that are cause for concern\(^1\), the retired population is in a generally more favourable financial position today than the working population. After having examined some of the specific measures for retired people, the Cour des Comptes surveys possible options for greater solidarity and greater equity between the generations.

A cost of around €12 billion\(^2\)

**Substantial tax relief**

Tax loopholes for income tax, which do not concern low-income retired people, provide growing support as the income level rises, so mainly benefit wealthy retired people.

The cost of the tax expenditure examined with regard to income tax comes to a total of around €4.5 billion (in particular the 10% discount on pensions even though retired people no longer have to pay professional expenses, and the exemption from pension increases for children).

The tax relief on local taxes granted to people over 60 cost €0.8 billion (exemption from the residence tax, the television licence fee and the tax on developed land).

**Costly welfare loopholes**

Whereas the universal social security tax (contribution sociale généralisée, CSG) is calculated at 7.5% for all people in employment, regardless of their remuneration, there are three different rates for retired people, depending on the value of their pension: 49% of retired people pay 6.6% in CSG, 12% pay 3.8% and 32% are exempted (2008 figures). This situation leads to inconsistency and threshold effects, and does not seem justified from an economic or social point of view, at least not for the highest pensions, especially as this measure (the 6.6% rate

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\(^1\) See previous chapter on old-age coverage for the poorest people.

\(^2\) The various retirement family benefits represent close to €15 billion. The latter include pension increases for parents of three children or more. The Cour des Comptes has requested on several occasions that they be taxed and/or capped.
Specific tax and welfare measures for retired people

rather than 7.5%) results in lost revenue of nearly €1.2 billion.

The pensions paid by the basic schemes have been exempted from health insurance contributions since 1998. A 1% health insurance contribution is still applied on complementary or supplemental retirement benefits.

All employers over the age of 70, whatever their income, are exempted from paying employer contributions up to a ceiling rate that can reach €245 a month. These exemptions represent a total cost of €0.4 billion.

Retired people generally better off than the rest of the population

Some pensioners, especially women, have low incomes, as shown in the previous chapter, and ageing gradually confronts them with a risk of loss of autonomy that incurs substantial expenses. Even so, the retired population as a whole has caught up with or even overtaken the income level of the rest of the population.

This catch-up effect, which was particularly noticeable up until the early 80s due to the ramp-up of the retirement schemes and a high revalorisation rate for pensions, is still continuing today. The new generations of retired people have accumulated higher pension entitlements. The average direct-entitlement pension (basic and complementary) reached €1,350 in 2010 as against €1,029 in 2004, which corresponds to an 8% increase in purchasing power.

Retired people also have higher average personal wealth than people in employment. In 2004, the average wealth of retired households was €252,700, as against €213,600 for working households.

Lastly, retired people have a higher standard of living than the rest of the population because they have financial income and because elderly people are more likely to be the owner-occupier of their primary residence than people in employment: this is the case for 72% of over-60-year-olds, as against 58% on average. According to the National Institute of Statistics and Economic Studies (Institut national de la statistique et des études économiques, INSEE), retired people’s average standard of living has nosed ahead of that of working people in recent years (respectively, €23,970 and €23,060 in 2006).
Specific tax and welfare measures for retired people

The need for change

Less justification for tax relief and welfare advantages

As some other categories of the population, and especially young workers, see their conditions deteriorate, it seems necessary to re-examine all of the existing support mechanisms, which still often date back to a time when the situation of the elderly was particularly precarious.

The issue is all the more pressing as public finances are under mounting pressure, additional demands have been placed on people in employment, and new needs are emerging: the cost of dependency or the cost of helping young people enter the workforce or obtain housing.

Gradually harnessing the room for manoeuvre

While being careful not to fragilise the most modest retired people, attention should be focused on four measures:

- remove the 10% discount on pensions for income tax (estimated saving: €2.7 billion);
- bring the CSG rate on the highest pensions into line with the rate applied to wages and salaries (estimated saving: €1.2 billion);
- remove the income tax exemption applied to pension increases for children (estimated saving: €0.8 billion);
- means-test the exemption from employer contributions for elderly individuals employing staff in the home.
Specific tax and welfare measures for retired people

Recommendations

58. As already recommended by the Cour des Comptes, gradually phase out the following tax expenditure and welfare loopholes:
- the 10% discount applied to pensions in the income tax declaration (saving: €2.7 billion);
- the exemption from income tax of the pension increases for parents of three children (saving: €0.8 billion);
- non-alignment of the CSG rate applied to the highest pensions (6.6%) on the rate applied to wages and salaries (7.5%) (saving: €1.2 billion).

59. Means-test the total exemption from employer contributions granted to certain categories of private-individual employers.

60. Extend the basis used to calculate health insurance contributions at the rate of 1% to include all complementary retirement pensions and basic pensions (above a certain threshold) when the distinction between these two types of pension benefits is not relevant.

61. Examine the consequences of eventually removing age-related tax relief on local taxes.
The means-testing of certain family benefits from the 1970s onwards gave family policy a new purpose. Alongside its traditional objective of off-setting differences in standards of living between families without children and families with children, it was now to help narrow income gaps among families with children.

The growing importance of benefits

Family benefits include the family supplement (complément familial, CF), the school benefit (allocation de rentrée scolaire, ARS) and the various components of the young child benefit (prestation d’accueil du jeune enfant, PAJE): birth or adoption bonus (primes de naissance ou d’adoption, PN), basic benefit (allocation de base, AB) and childcare supplement (complément de mode de garde, CMG).

Unlike universal benefits such as the family benefits, these benefits are granted after means-testing or adjusted to the family’s resources.

This particular dimension of family policy, which is more specifically concerned with its welfare objective, accounted for 44% of the total volume of family benefits in 2010, as against 29% in 2000, i.e. over €13 billion. This growth stems mainly from the increase in the CMG benefit, as the other benefits tended to decline. The 25% increase in the ARS adopted in the summer of 2012, which should be offset by adjusting the family quotient for a similar amount, represents additional expenditure of €0.4 billion for the division.

A lack of overall consistency

Means-tested benefits address very different objectives: the expenses incurred in caring for young children (PN and AB components of the PAJE) or schooling (ARS), support for large families (CF), or help with reconciling family life and work life (the CMG component of the PAJE). As a result, each type of benefit has specific, highly changeable eligibility rules, and the monetary value varies substantially from one benefit to the next.

The ceilings applied to means-tested benefits reflect a more or less accentuated targeting, with no overall consistency, and which is accordingly very disparate.

The CMG benefit is in a class of its own because, although the amount varies according to the family’s
resources, all families, whatever their income level, can receive this benefit. It amounts to €171 a month for one child, whether the family has a monthly income of €4,000 or €20,000.

Nor is the amount of the benefits dictated by a consistent approach to the cost of the child.

**Little effect on income levelling**

An average 34% of the families eligible for these benefits have incomes that are too high for them to receive them. This shows a generally moderate selectiveness: very low for the AB component of the PAJE, which is an almost universal benefit, and much higher for the ARS.

As far as vertical income redistribution is concerned, the true means-tested benefits (the AB and PN components of the PAJE, the CF and ARS benefits) have only limited effects on families’ incomes and reducing the poverty rate.

The CMG benefit, which varies with the family’s resources, is mainly paid to wealthy families.

**A smaller role in income levelling than the universal benefits**

Among the benefits associated with young children, the non-means-tested benefits have the most noticeable income-levelling effects (60%), ahead of the means-tested benefits (40%). This situation can be attributed to the higher volume of the former. Among these benefits, the AB component of the PAJE does the most to level incomes since, even if it is not very progressive by comparison with the CF or the ARS, it represents a large financial sum. On the other hand, it is the wealthier families who benefit most from the CMG, since there is no ceiling. The volume of CMG benefits has increased sharply in recent years and it now tops €5 billion. Out of this total, families in the ninth and tenth standard-of-living deciles received €2.1 billion in CMG benefits in 2009.

In all, the lower 50% of households - which represent only 30% of income - account for 75% of means-tested benefits and receive only 20% of the benefits that vary with the family resources.
Revise the overall economy of means-tested benefits

Lowering the resource ceiling for the AB, which is particularly high, and introducing a resource ceiling for the upper bracket of the CMG would free up considerable financing capacity that could be redeployed to benefit the most modest families without adversely affecting the need to make up the deficit in the Family Division.

Recommendation

62. Revise the overall economy of family benefits that are either means-tested or adjusted according to resources:

- give greater priority to the objective of supporting vulnerable families;
- reform the AB and CMG components of the PAJE benefit to target a narrower group of beneficiary families, and apply a resource ceiling for receiving the CMG benefit.
Direction and management of the information system of the general scheme’s Family Division

The next 2013-2016 objectives and management agreement (convention d’objectif et de gestion, COG) between the State and the national fund must be used to completely redefine the strategic objectives and the procedures for directing and managing the division’s IT system, which have major shortcomings. The quality of service for over 11 million recipients who receive €77 billion in benefits depends heavily on this initiative, as do the efficiency gains in a division that employs 31,000 people (FTE).

Vague strategic priorities

The last three COG gave the National Family Benefits Fund (Caisse nationale des allocations familiales, CNAF) too many objectives without setting any real priorities. The information system master plans, which are designed to implement the COG objectives, have the same flaws and lack the capacity to anticipate or respond swiftly. They are only partially carried out.

Governance shortcomings

The State bears major responsibility

The State is largely responsible for the weaknesses in the information system’s management tools. When it inspired and signed COG that contained too many objectives, the supervisory authority did not give sufficient consideration to the CNAF’s ability to achieve them.

Moreover, the State has made a string of changes to the regulations without giving sufficient thought to their consequences in terms of changes to the information system. Each new measure requires IT development work, which the CNAF often has to carry out as a matter of urgency, setting aside scheduled work and without proper knowledge of the operational constraints. For instance, the State stipulated that the set of sanctions applicable to recipients of the active solidarity income (Revenu de solidarité active, RSA) was to be introduced in April 2012, even though the CNAF had
Direction and management of the information system of the general scheme’s Family Division

said that it could not consider bringing the scheme in until early 2013.

The CNAF feeling its way

The CNAF must shoulder its management role and take steps to conduct these projects more firmly and rigorously.

Despite a reorganisation of the network when the process of departmentalising the CAF was finished, splitting up the operational organisation set up to administer and upgrade the information system is detrimental to the division’s efficiency and the transparency of its management.

The CNAF needs to tighten and clarify its IT governance, develop fewer projects and drastically simplify the operational structures.

The CNAF is aware of the drawbacks of a system designed in the past by a division that was not very centralised, and plans to reorganise its system by setting up regional data processing centres, though without having thoroughly analysed the location of these structures.

Management shortcomings

The Family Division’s IT staff is spread over numerous organisations and no-one is sure of the total headcount.

Additionally, for want of criteria for the distribution of responsibilities among these structures, IT procurement contracts are sometimes concluded by the CNAF and sometimes by the CAF or the regional data processing centres. The result is a confusion of responsibilities and the fact that the CNAF has only patchy knowledge of the consolidated amount spent on IT.

Worrying delays in modernisation

Given the number of projects under way, there does not currently appear to be sufficient capacity for developing the main applications.

The CNAF does not yet have a centralised tool for tracking the division’s IT resources and their allocation to different projects. The application it designed in 2006 does not allow it to carry out this tracking. A contract for “Family Division management support” is filling the gap to some extent.

The CNAF is aware that its current management software is obsolescent and problematic, and plans to buy a new tool that, however, will not be operational until the beginning of the next COG.
Direction and management of the information system of the general scheme’s Family Division

Recommendations

63. Focus the next COG on a handful of ranked priorities, oblige the CNAF to allocate the necessary resources for achieving them, and carry out an annual performance review.

64. Consolidate the CNAF’s role in managing the information system and ensure that it organises project management and requirements specification in accordance with best practice.

65. Stringently rationalise IT structures around a significantly smaller number of centres that are far more closely linked with the CNAF, and ban the CAF from undertaking any local developments.

66. Make adoption of the next master plan contingent on the CNAF’s possession of the necessary tools for monitoring projects, available resources and costs.

67. Systematically seek the CNAF’s opinion, beforehand, on the technical feasibility of any legislative or regulatory changes affecting it.
Daily sickness benefits paid by the general scheme

A dynamic expenditure whose determinants have not been sufficiently analysed

The daily sickness benefits paid by the general social security scheme amounted to €6.4 billion in 2011.

They have increased by almost 50% since 2000, from €4.3 billion to €6.4 billion in 2011. Despite the substantial sums involved and the dynamics of this expenditure, which is only partially linked to the increase in the total payroll, the amount of analysis done on sick leave is very insufficient. For instance, the differences observed in the frequency and duration of sick leave between one part of the country and another remain largely unexplained: if we take out Paris and the Hauts de Seine, sick leave ranges from 6.5 to 13.2 days’ paid leave per employee from one department to the next. This lack of knowledge prevents stakeholders defining a real regulation policy, which largely remains to be constructed.

Firmer, steadier direction needed

A control policy to be redefined

The numerous measures for controlling the insured lack overall consistency. Their overlap, disparate implementation and vague targeting make the policy difficult to grasp. This lack of clarity is compounded by problems of liaison between the funds’ administrative services and those of the medical consultant. For this reason, it seems indispensable to redefine the objectives of these services and the methods used for controls, especially as they will be able to use new tools currently being developed by the health insurance system.

Given the low rate of fraud detected in paid sick leave claims, the anti-fraud policy should be updated to include tools capable of more systematically detecting fraud and especially organised fraud.
Daily sickness benefits paid by the general scheme

Regulation needed, especially for prescribers

For want of a coherent regulation approach, steps must be taken to raise awareness of the issues among all of the stakeholders - people insured by the social security system, employers and doctors - using specific measures for each stakeholder. Employers should be involved more closely, given that they provide extensive complementary cover for the great majority of employees. In practice, over 65% of employees are no longer left without pay for the first three days of their illness before social security sickness benefits start to be paid. But a proactive campaign aimed at doctors, who initiate the expenditure, is essential. Measures to regulate sick leave prescriptions should no longer be confined to the heavy prescribers or private practitioners alone. While general practitioners prescribe an average of 2,700 days’ sick leave each, doctors in the tenth decile prescribe 7,900 days.

To ensure that all prescribers are concerned, targets to regulate sick leave prescriptions are now included in the negotiation of the agreement.

Hospital doctors should also be included in measures to regulate prescriptions: the difficulty of tracing prescriptions has so far left them out of the regulation tools used with private practice doctors.

Simplify the regulations: a prerequisite for improving efficiency and quality

Vital efficiency gains

Managing daily sickness benefits represents a heavy workload for the health insurance system. It occupies 5,300 administrative FTEs for all of the risks - close to 10% of the funds’ workforce - for a benefit that represents approximately 6% of the total expenses of the sickness and workplace accident-occupational disease (accident du travail-maladie professionnelle, AT-MP) divisions.

The complexity of the regulations results in numerous assessment errors, with a heavy financial impact (roughly €50 million in 2011).

Quality of service needs to be improved

The current regulations are also an obstacle to improving quality of service. The expected gains from projects to make the process paperless are today largely limited by the complexity of the process, which makes it impossible to automate the assessment of a substantial proportion of the claims (40% at this stage). This situation also accounts for the difficulty of shortening the average payment lead time (38.5 days in 2011). Sometimes the lead time for paying the insured is far too long and can reach hundreds of days. This is especially hard for employees in
difficult circumstances, for whom a discontinuity in their remuneration has more serious consequences.

The necessity of a simplification, which is always talked about and always postponed, cannot be put off any longer. This is especially true as it largely determines the successful outcome of the nominal social security reporting project, which was adopted in principle in 2012 and will become required practice on 1 January 2016.

This form of reporting is designed to replace almost all employer social security reports, but cannot be envisaged under the current regulations without making the procedure more complicated. Apart from the necessity of simplifying certain points of the regulations, especially those concerning the information that employers are required to provide in the wages statement, the simplification project should also strive to harmonise the basis used to calculate daily sickness benefits, maternity benefits and AT-MP benefits, which is specific to each risk. When the next CNAMTS objectives and management agreement is drawn up, the opportunity should be taken to thoroughly modernise a benefit whose basic characteristics have hardly changed since the inception of the social security system.

**Recommendations**

- 68. Refine and update studies on the determinants of sick leave.
- 69. Accentuate and extend initiatives to make the medical profession more aware of its responsibilities. This will mainly consist in including an objective of compliance with the prescription guidelines in private practice doctors’ performance-based remuneration, and making hospital doctors, and especially heavy prescribers, subject to regulation.
- 70. Evaluate and redefine the principles for running administrative checks on the insured. Redefine the objectives and the methods for medical checks in terms of targeting and consistent practices.
- 71. Introduce the tools and methods necessary for systematically detecting fraud and especially organised fraud.
- 72. Modernise and simplify the regulations, essentially by harmonising the basis used for calculating the different types of daily sickness benefits.