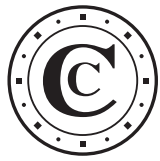
Cour des comptes



PUBLIC FINANCE AND ACCOUNTS

SOCIAL SECURITY

Report on the implementation of the Social Security Finance Acts

Summary

October 2019

DISCLAIMER

This document is intended to facilitate reading of the Cour des Comptes Report, which alone is binding on the Court. Responses received from administrations and bodies concerned have been incorporated into the Court's Report.

The order of chapters summarised is the same as in the full Report.

Summary

Summary

Presentation

Since the early 1990s, the French social security system has been in constant deficit (save for a short-lived remission in 2000-2001), which the 2009 economic recession pushed to unprecedented levels. Over the long term, it is faced with challenges of financial sustainability connected with a lasting slowdown in growth, the consequences of population ageing on pensions and healthcare needs, and an increase in chronic pathologies.

In 2018, the social security deficit continued along the reduction path it had been on since 2011, and almost disappeared altogether. The 2019 Social Security Finance Act had anticipated a return to balance as from 2019. Just a few months later, however, this forecast came to be seen as highly improbable. According to the 2020 Social Security Finance Bill (Projet de Loi de Financement de la Sécurité Sociale – PLFSS 2020), the social security deficit will increase once again in 2019, with achievement of financial balance delayed until 2023.

In the extension to its last report on the situation of and perspectives for public finances taken as a whole (State, social administrations and local authorities)[1], as in its reports issued in previous years on application of Social Security Finance Acts, the Court focused on studying the system's financial trajectory over the course of the years to come.

Rapid achievement of lasting financial balance on the part of the social security system, independently of the ups and downs of the economic situation, is essential if we are to completely wipe out the social debt resulting from past deficits and avoid it building up again to the detriment of future generations.

Taking account of the levels reached by compulsory levies, such a goal requires that greater efforts be made to control expenditures in a situation where these latter tend to increase more quickly than the economy's potential growth, which determines the evolution of revenue from social security contributions at a constant levy rate.

Making use of replacement incomes paid out by health and old-age insurance funds more selective, making the actors in our healthcare system who initiate health insurance payments more accountable, reducing the errors that all too often impact the benefits paid out by social security funds and changing the service relationship between these latter and insured parties, in particular by use of digital tools, are all possible levers to mobilise in order to achieve long-term financial balance on the part of our social security system.

[1] Cour des Comptes, La situation et les perspectives des finances publiques (Public Finances: Situation and Prospects) June 2019, La Documentation Française, available on www.ccomptes.fr.

1 The Social Security system's financial situation and prospects: a postponed return to balance and a need for greater control of expenditures

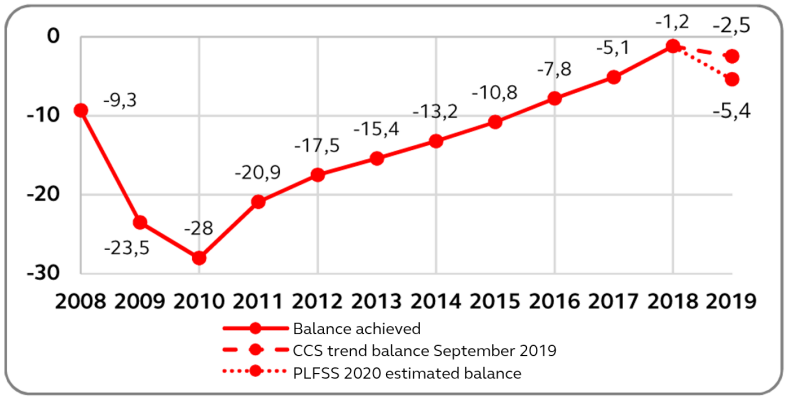
A near return to balance in 2018

In 2008, the deficit recorded by mandatory basic social security schemes and the Old-Age Solidarity Fund (Fonds de Solidarité Vieillesse - FSV) reached €8.9 Bn. The 2009 economic recession's effects on social security revenue brought it to an unprecedented €29.6 Bn in 2010.

Between 2011 and 2018, the social security and FSV deficit was steadily reduced as a result of revenue-raising measures implemented up until 2014, an unprompted increase in revenue as from 2015 and efforts to control expenditures (the 2010 and 2014 pension reforms, a reduced rate of increase in expenditures in line with the growth norm for healthcare expenditure (objectif national de dépenses d'assurance maladie – ONDAM), and reform of family allowances and the early childhood benefit).

In 2018, the social security and FSV deficit was significantly reduced, to -€1.4 Bn, including -€1.2 Bn for the general scheme and FSV, as against -€4.8 Bn and -€5.1 Bn respectively in 2017.

Evolution in the aggregated deficit of the general scheme and the FSV (2008-2019, in €Bn)



Source : Cour des Comptes, based on data contained in the September 2019 report by the Social Security Accounts Commission (CCSS) and the PLFSS 2020.

[2] Which finances a portion of non-contributory pension rights.

The Social Security system's financial situation and prospects: a postponed return to balance and a need for greater control of expenditures

Following the AW/OD branch (in 2013), the family branch returned to balance in 2018, after ten years of deficit. The old-age branch has also been in balance since 2016, but the combined old-age branch and FSV is still in deficit (€1.6 Bn in 2018). Due in particular to new revenue in its favour, the sickness branch's deficit has been greatly reduced (to €0.7 Bn as against €4.9 Bn in 2017).

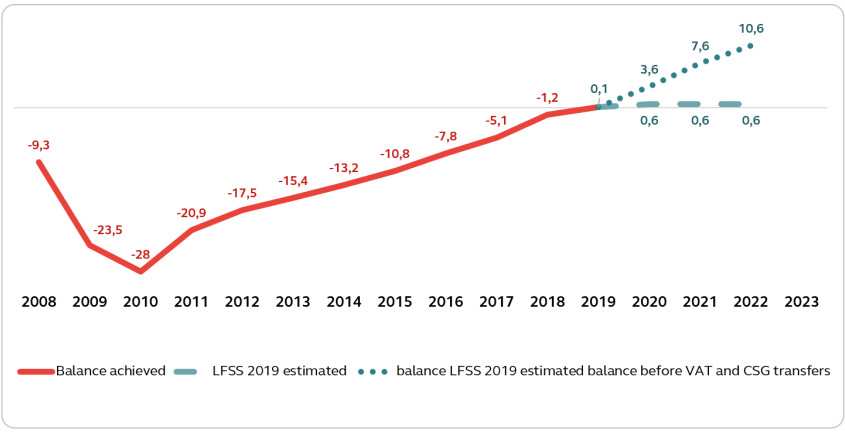
The social security system's near return to financial balance in 2018 is the result of a sustained increase in the payroll (+3.5%), which is responsible for ¾ of social security financing, a significant increase in levies on capital income, in line with the institution of the single flat-rate levy (prélèvement forfaitaire unique – PFU) in 2018, and revenue-raising measures implemented (+€1.6 Bn).

Hence, revenue dynamics have outstripped expenditure dynamics, which have accelerated nonetheless: in constant terms, they increased by +2.4% in 2018, after +2% in 2017 and +1.6% in 2016. Expenditures relating to the ONDAM increased at the same pace as in 2017 (+2.2%). There was a greater increase in old-age insurance expenditures, however (due to a more rapid increase in numbers of retirees and the effect of full-year revaluation of pensions in 2017).

Instead of a return to balance in 2019 followed by a trend towards ever increasing surpluses, significant growth in the social security deficit

The 2019 Social Security Finance Act (LFSS 2019) anticipated the social security system's return to balance in 2019, for the first time since 2001, with a slight surplus.

Financial trajectory of the general scheme and Old-Age Solidarity Fund (FSV) in the 2019 Social Security Finance Act (LFSS) (in €Bn)



Source : Cour des comptes.

The Social Security system's financial situation and prospects: a postponed return to balance and a need for greater control of expenditures

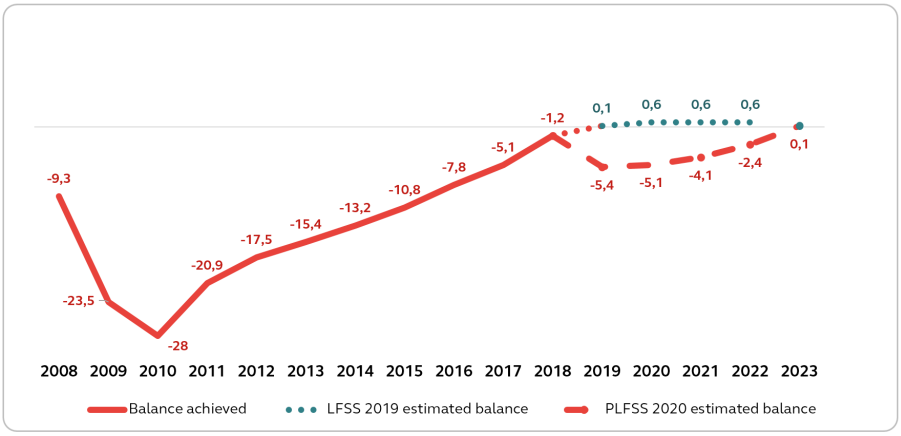
Social security schemes and the FSV should record growing surpluses as from 2020. Such surpluses should enable combination of a lasting social security balance (with a slight annual surplus, below €1 Bn) with reallocation to the State of a percentage of VAT revenues transferred to social security (to the tune of €5 Bn overall in 2022) and transfer of revenue from the Generalised Social Contribution (Contribution Sociale Généralisée–CSG) to the Social Security Debt Redemption Fund (Caisse d'amortissement de la dette sociale – CADES) (to the tune of €5 Bn overall in 2022).

Transfer of CSG revenue to CADES should enable the Fund to reassume up to €15 Bn in deficits whose financing is ensured by short-term loans issued by the Central Agency of Social Security Bodies (Agence centrale des organismes de sécurité sociale – ACOSS); the deficit balance financed by ACOSS (around €8 Bn) should be paid off by general scheme and FSV surpluses.

This scenario, which was based on an optimistic hypothesis of payroll increases (from +3.5% to +3.8% depending on year), is no longer valid.

According to the 2020 Social Security Finance Bill (PLFSS 2020), t**he general scheme and FSV deficit should reach €5.4 Bn in 2019**, €4.2 Bn higher than in 2018 and €5.5 Bn higher compared with the LFSS 2019 projection.

Financial trajectory of the general scheme and Old-Age Solidarity Fund (FSV) in the 2020 Social Security Finance Bill (PLFSS) (in €Bn)



Source : Cour des comptes.

The Social Security system's financial situation and prospects: a postponed return to balance and a need for greater control of expenditures

Two factors, of equal importance financially speaking, go to explain the **€5.5-Bn** gap between the PLFSS 2020's and LFSS 2019's projections.

Firstly, the cost **(€2.7 Bn)** of the economic and social emergency measures implemented at the end of 2018 (re-establishing a 6.6% CSG rate for less well-off retirees and moving forward exemption from social contributions on overtime hours to 1 January 2019), not compensated by the State, and secondly, gaps compared with revenue and expenditure projections taken into account by the LFSS 2019 **(€2.8 Bn)**.

As far as revenues are concerned, particular account must be taken of the fact that the payroll subject to contributions should increase less than forecast (+3% rather than +3.5%), with an impact of some €1 Bn.

As regards expenditures, their acceleration (+2.5% as against +2.4% in 2018 and the +2.1% initially projected in the LFSS 2019) should increase the deficit balance by €1.4 Bn compared with the projection. Pensions are mainly to blame for the projection being exceeded. In addition, health insurance expenditures will remain dynamic in 2019: the growth norm for healthcare expenditure (ONDAM) adopted in the LFSS 2019 corresponds to a higher expenditure growth rate (+2.5%) than that observed for 2018 (+2.2%).

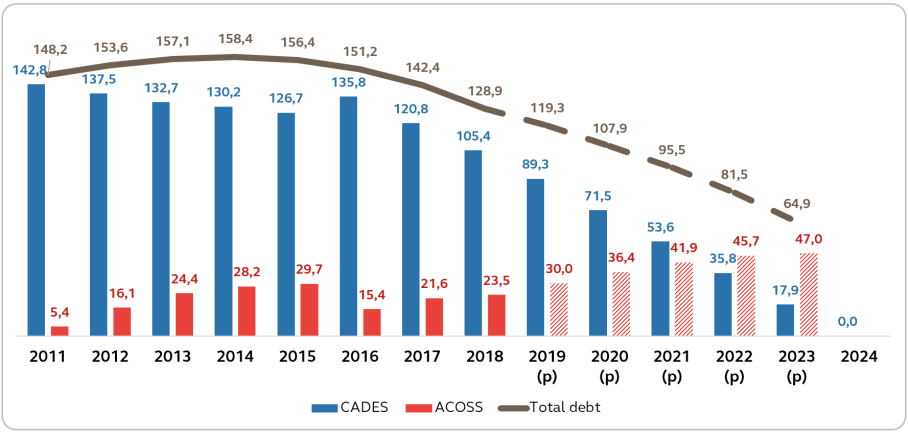
Looking beyond 2019, these various factors have led the Government, in the PLFSS 2020, t**o postpone the general scheme's and FSV's return to balance to 2023** and reconsider retrocessions of VAT to the State and CSG transfers to CADES.

The prospect of a continued increase in the debt accumulated at ACOSS

Thanks to the resources allocated to the Agency (€15.6 Bn in CSG and Social Debt Repayment Contributions (*Contribution pour le remboursement de la dette sociale* – CRDS) in 2018 and an annual levy of €2.1 Bn on the Pension Reserve Fund (*Fonds de Réserve pour les Retraites* – FRR) between 2011 and 2024), the debt to be paid off by CADES should be in the region of €89.3 Bn at end 2019, out of the €260.5 Bn transferred to it since its creation in 1996.

With no change in resources, the debt should be fully paid off in 2024. The foreseeable increase in the general scheme and FSV deficit will have no impact in this regard. However, it makes any prospect of progressive extinction of the social security debt maintained at ACOSS ever more distant.

Evolution of the social debt borne by the Social Security Debt Redemption Fund (CADES) and the Central Agency of Social Security Bodies (ACOSS) (in €Bn)



Source : Cour des comptes.

The PLFSS 2020's financial trajectory leads to fresh accumulation of general scheme and FSV deficits (apart from the AW/OD branch) of almost €16 Bn between 2020 and 2022. Hence, all things being equal, ACOSS will have to finance almost €46 Bn over the short term by end 2022 – a level approaching the €50 Bn in cash requirements that ACOSS had to deal with at end 2010, when the effects of the recession generated by the 2008 financial crisis were at their peak.

This situation is all the more troubling in that it is set to come about in a still favourable economic context.

A necessary change in the pace of expenditure increases

In the space of a few months, between the adoption of the LFSS 2019 and that of the PLFSS 2020, the social security system's return to financial balance was delayed by four years.

However, the social security system's lasting return to financial balance cannot be ensured by a simple temporal shift in a financial trajectory whose revenue and expenditure parameters remain unchanged.

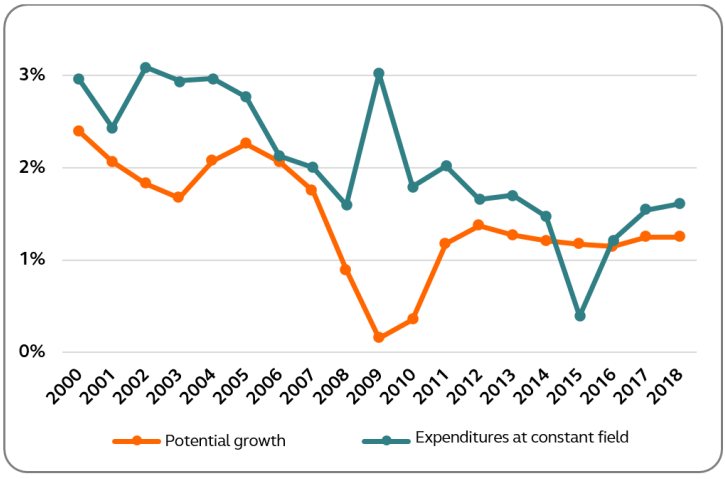
The Social Security system's financial situation and prospects: a postponed return to balance and a need for greater control of expenditures

Any long-term financial balance on the part of the social security system requires a structural balance independent of any impacts that variations in the economic situation might have on the evolution of revenues. Yet the Court estimates that the general scheme and FSV still recorded a structural deficit of €1 Bn in 2018.

In the absence of new revenue measures (implementation of which the level already reached by mandatory levies makes difficult), achievement of a structural financial balance on the part of the social security system requires that its expenditure dynamics be reduced to a level below or equal to the potential growth of national wealth, to which the pace of any trend in growth of the revenues allocated to it corresponds.

Yet since 2000, with the exception of 2015, despite the efforts to economise made since 2011, social security expenditures assessed on a constant-field basis have systematically increased more rapidly than potential GDP growth.

Comparative evolution of the rate of increase of mandatory basic social security scheme and FSV expenditures and potential GDP growth (in volume, in %)



Source : Cour des Comptes and April 2019 Stability Programme.

Two areas pose specific challenges to the social security system's return to balance.

If there is no change in policy, the pension system's financial situation is likely to deteriorate by 2030. According to work productivity gains scenarios and other hypotheses adopted by the Pensions Advisory Council (Conseil d'Orientation des Retraites – COR), the pension system's balance would stand at between -0.2% and -0.8% of the GDP. The expenditure to GDP ratio would remain stable or increase

slightly, while unprompted evolution of revenues would be less dynamic.

The growth norm for healthcare expenditure (ONDAM) has been complied with for the last nine years. However, given the measures to increase the salaries of many of the healthcare system's actors (in particular pursuant to agreements concluded with various professions), return to an annual 2.3% rise as from 2020, after 2.5% in 2019, supposes marked improvement in control of expenditures on other items.

It is also important that all expenditure sectors, including ambulatory care, contribute to achievement of the ONDAM over the course of the year, whereas they have so far been largely exempt (apart from medicines). In addition, keeping to the ONDAM must not result in any increase in hospital deficits, which almost doubled in 2017 (€865 M as against €461 M in 2016), unless their reduction in 2018 (€660 M according to provisional data) enables a return to their previous level.

Recommendations

1. Adopt structural savings measures that target expenditures and enable acceleration of the social security system's and FSV's return to balance.

2. In the context of a revised financial trajectory, define a plan for wiping out the social security debt maintained at ACOSS.

3. Incorporate the objective of controlling public healthcare facilities' deficits and debts into construction of the ONDAM (reiterated recommendation).

Social Security balance sheet tables and asset table for financial year 2018: opinion on consistency

The legislature has entrusted the Court with the mission of checking the consistency of social security balance sheet tables and asset table for the last financial year.

These tables, which are established by the Ministry responsible for social security, are subject to Parliament's approval in the context of the annual Social Security Finance Bills.

When preparing its opinions on these tables, the Court ascertains that the information they contain is consistent with accounting data, that inter-institutional transactions have been eliminated, and, more generally, that Parliament is provided with quality information.

The Court deems that, for the most part, the tables relating to financial year 2018, which are submitted to Parliament in the context of the 2020 Social Security Finance Bill (PLFSS), provide a consistent representation of a part of the revenues, expenditures and balance (balance sheet tables) and of the assets and liabilities (asset table) of the social security entities included in their respective scopes.

Balance sheet tables: reduction of scheme and FSV deficits

Three separate balance sheet tables, presented by branch, cover products ("revenues"), charges ("expenditures") and results ("balance") of all mandatory basic social security schemes, the general scheme, and the Old-Age Solidarity Fund (FSV). Hence, they constitute combined profit-and-loss accounts.

Presented in the form of overall totals, "revenues" and "expenditures" are detailed in an appendix to the annual Social Security Finance Bill. This year, however, the Court was unable to examine the corresponding draft prior to its submission.

The balances figuring in the balance sheet tables for 2018 are consistent with accounting data and attest to a further reduction in the social security deficit:

- in 2018, taken together, mandatory basic social security schemes, including the FSV, recorded a deficit of -€1.4 Bn (as against -€4.8 Bn in 2017);

- the general scheme's deficit, including the FSV, was reduced to -€1.2 Bn (as against -€5.1 Bn in 2017).

However, as in previous years, the balance sheet tables were presented with contractions of revenues and expenditures, so underestimating totals compared with schemes' accounts (€15.8 Bn for all basic schemes, including €14.4 Bn for the general scheme).

The quality of the accounting data summarised in the balance sheet tables could also be better. Continuing inadequacies in internal auditing, along with accounting difficulties, are the root causes of the reservations expressed by the Court on the financial states of the general social security scheme's branches and by the auditors on those of other schemes.

Among other things, the abovementioned inadequacies in internal auditing result in frequent errors being made with regard to benefits paid out.

The asset table: fresh improvement in the asset situation of the social security system as a whole

The asset table is a combined balance sheet for the general social security scheme, other schemes, the Old-Age Solidarity Fund (FSV), the Social Security Debt Redemption Fund (CADES) and the Pension Reserve Fund (FRR).

The assets and liabilities presented in the asset table for 2018 are consistent with accounting data.

The asset table attests to further improvement in the social security system's asset situation:

- for the fifth year running, the social security system, CADES and FRR included, has recorded a positive balance (€14.9 Bn in 2018, after €12.6 Bn in 2017). Since 2014, the general scheme's and FSV's deficit has been less than the surpluses recorded by CADES and, to a lesser extent, by the FRR. In 2018, the corresponding gap continued to grow under the effect of continued reduction of the general scheme's deficit and growth of CADES surpluses;

- under the effect of this positive result, the social security system's aggregate negative equity, a reflection of deficits not yet paid off by CADES, was further reduced (-€77 Bn at end 2018 after -€88.5 Bn at end 2017);

- once again, financial debt, which corresponds to the difference between financial liabilities[3] and assets[4], also decreased (€86.8 Bn at end 2018 as against €102.9 Bn at end 2017).

[3] For the most part, the social security system's financial debts are borne by CADES and ACOSS.

[4] For the most part, financial assets are held by the FRR and Banque de France, on behalf of the Bank's special pension scheme..

To a lesser extent than for balance sheet tables, certain reservations expressed by the Court and auditors on social security schemes' financial states have an impact on the quality of accounting data incorporated into the asset table.

Recommendations

4. Put an end to contractions of products and charges in balance sheet tables, a practice non compliant with the normative framework set by the bylaw relating to social security finance acts for establishment of mandatory basic social security schemes' accounts (reiterated recommendation).

2 "Social tax expenditure": dynamic, inadequately managed mechanisms in need of rationalisation

As with State tax expenditures, in current parlance, the term "social tax expenditure" is taken to refer to mechanisms for derogation of liability to social security levies that reduce their yield.

There are two major categories of derogation mechanisms:

- tax base exemptions, i.e. total or partial exclusion of various of the tax base's pay items subject to levies (or application of a flat-rate tax base). Such exemptions usually seek to promote special forms of remuneration;

- exonerations, i.e. reductions in rates or totals. These usually seek to reduce the cost of work through general reductions in contributions or exonerations targeting certain activity sectors or specific geographical and public areas.

Numerous mechanisms with often poorly traced costs

Since the 2006 Social Security Finance Bill (PLFSS), the object and cost of "social tax expenditure" as regards mandatory basic schemes and the Old-Age Solidarity Fund (FSV) have been described in a special document: Appendix 5 to annual PLFSSs.

According to Appendix 5 to the 2019 PLFSS, no fewer than 90 "social tax expenditure" may be applied to mandatory basic social security scheme and FSV revenues. According to the Appendix's summary table, the projected cost of such "niches" should reach **€66.4 Bn** in 2019 (after correction of a number of material errors).

Despite a measure of progress, identification and costing of the derogation mechanisms in Appendix 5 fluctuates depending on the benchmark adopted to assess them and how they are applied. They remain incomplete.

For 2019, without claiming to be exhaustive given the sheer number of such mechanisms and the fact that they are often difficult to cost, the Court evaluates the projected total of the main exonerations and exemptions applicable to mandatory basic social security schemes and the FSV at over **€90 Bn**, including €52 Bn for general contribution reductions alone.

"Social tax expenditure": dynamic, inadequately managed mechanisms in need of rationalisation

The gap between these two figures – some €25 Bn – has various causes: no account being taken of mechanisms created by the social security system's own policies[5]; no or only partial costing of numerous mechanisms; reduction of the cost of tax-base exemptions; and failure to include various mechanisms in the Appendix 5 summary table, despite their having been costed.

At least **€17 Bn** must be added to this with respect to legally mandatory social protection schemes initiated by social partners (supplementary pensions for employees and unemployment insurance).

Of course, the "social tax expenditure" totals indicated correspond to their gross cost. They are not supplementary revenue totals that the social security system could benefit from if "social tax expenditure" were abolished. "social tax expenditure" beneficiaries would then take new decisions on employment, remuneration and investment that would retroact on social security revenues.

Highly inadequate management of the cost of "social tax expenditure"

Between 2013 2019, the recorded cost of "social niches" almost doubled, rising from €34 Bn to over €66 Bn, within the meaning of Appendix 5 to the PLFSS.

This increase mainly reflects the reinforcement of general reductions in social security contributions (+€26.2 Bn) in the context of the employment support policy. It is largely the result of Responsibility Pact measures implemented between 2014 and 2017 (€9 Bn) and the transformation of the Tax Credit for Competitiveness and Employment (Crédit d'impôt pour la compétitivité et l'emploi – CICE) into general reductions in 2019 (€18 Bn).

Despite the reinforcement of general reductions, the recorded cost of targeted exonerations has not gone down. It has even increased (+€1.6 Bn[6]), under the effect of the exemption from social contributions on overtime hours enacted on 1 January 2019.

The mechanisms for capping the cost of or revising "social tax expenditure" provided for in Public Finance Programming Acts are not robust enough to have any real effect.

Moreover, assessments of the effectiveness of "social tax expenditure" have no noticeable effect on public choices. They bear on a partial field of application and their methodology is not equally robust. When assessments point to the inefficiency of certain "niches", these latter are seldom called into question.

The network of Social Security and Family Benefit Contribution Collection Offices (*Unions de Recouvrement des cotisations de Sécurité Sociale et d'Allocations Familiales* – URSSAFs) does not do enough to reduce the risks connected with companies' application of "social tax expenditure". It should be more efficient in targeting tax-base audits and in detecting and correcting increasing numbers of anomalies upstream, by universalising automated consistency checks on data declared by employers in their Nominative Social Declarations (*Déclarations sociales nominatives* – DSNs).

[5] Exemptions connected with the early childhood benefit (PAJE) and benefits allocated to contracted medical practitioners and paramedics.

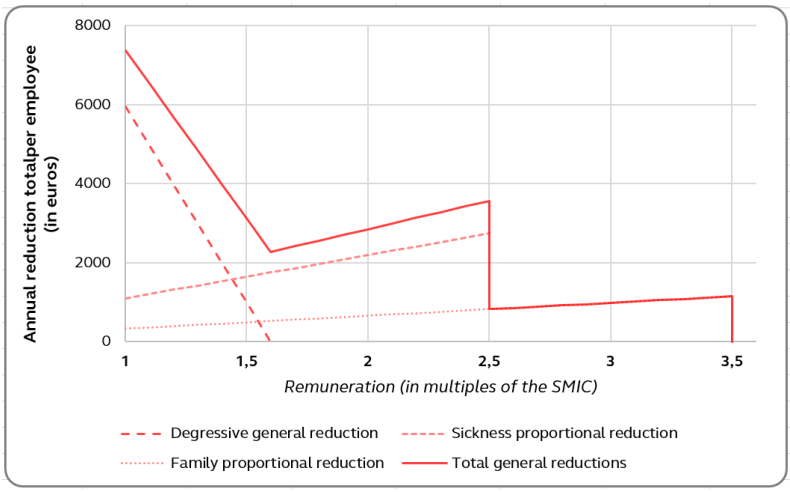
[6] Excluding any impact of incorporating various targeted exonerations into general reductions.

Clarifying the boundaries of “social tax expenditure” and reducing their cost

The number and magnitude of “social niches” lead to a disparity between general taxation rates and the actual level of social security levies. The more general reductions of contributions are increased, the more the gap widens. The resulting lack of clarity in levies on wage income may make France less attractive in the eyes of national and international economic actors.

Incorporation of general reductions into the ordinary scale for contributions is desirable but has prerequisites. In particular, fresh assessments need to be carried out on the effectiveness of the general reductions profile with regard to employment, companies’ competitiveness and distribution of salaries, in terms of such reductions’ exit points and the threshold effects that result from them.

Profile of general reductions in employers’ contributions in 2019



Source : Cour des comptes.

In general, the effectiveness of derogation mechanisms should be assessed using robust statistical methods and any consequent steps taken: either abolishing ineffective mechanisms or closing off their access to new beneficiaries. The methods and results of and possible follow-up action to such assessments should be brought to Parliament’s knowledge in Appendix 5 to the PLFSS.

While awaiting the results of robust assessments, such mechanisms’ uncertain effectiveness should lead to organisation of their attrition. To this end, reference values of parameters used to calculate a benefit or its ceiling should be frozen at their current level.

Finally, an immediate end should be put to the most evident windfall effects. In particular, the social security contribution base’s Specific Flat-Rate Deduction (Déduction forfaitaire spécifique – DFS), which enables flat-rate assessment of professional expenses for certain professions (€1 Bn or €1.5 Bn after impact on the cost of general reductions), should be called into question.

Any justification of the DFS is called into question by the ongoing extension of general reductions and abolition in 2001 of this particular advantage in the tax field (except for journalists), which had historically justified its application in the social field.

Recommendations

5. In Appendix 5 to the PLFSS, clarify the “social tax expenditure” reference standard, identify and cost these mechanisms on the widest possible scale, in homogenous fashion stable over time, and provide exhaustive information on their financial compensation by the State, however it is carried out (Ministry responsible for social security).

6. Continue assessment of general reductions; use robust statistical methods to assess “social niches” greater than €100 M and abolish or close off inefficient mechanisms (Ministries concerned with derogation measures).

7. Freeze reference values for calculation of the benefits or ceilings of “social niches” greater than €100 M whose efficiency has not been demonstrated by assessments based on robust statistical methods (Ministry responsible for social security).

8. Ensure that general reductions of companies’ contributions are reliably applied by universalising automated checks of the consistency of exemption totals declared for all employees (in terms of the sum of the totals declared per employee) and for each of them individually (in terms of individual data on pay and working time) (ACOSS).

3 Daily allowances: increasing expenditures on health risk cover, a need to control absences from work

Daily allowances are replacement incomes that *Assurance Maladie* (France's National Health Insurance) pays to employees whose state of health requires them to stop working temporarily. They cover three separate risks: illness, accidents at work and occupational diseases (AW/OD) and maternity.

Expenditures on compensation for absences from work due to illness are especially dynamic. In order to control them, it is essential that all actors – prescribing physicians, patients and employers alike –are made more accountable. There also needs to be a reduction in unjustified or avoidable expenditures made by *Assurance Maladie* due to suboptimal management methods.

Strong expenditure dynamics

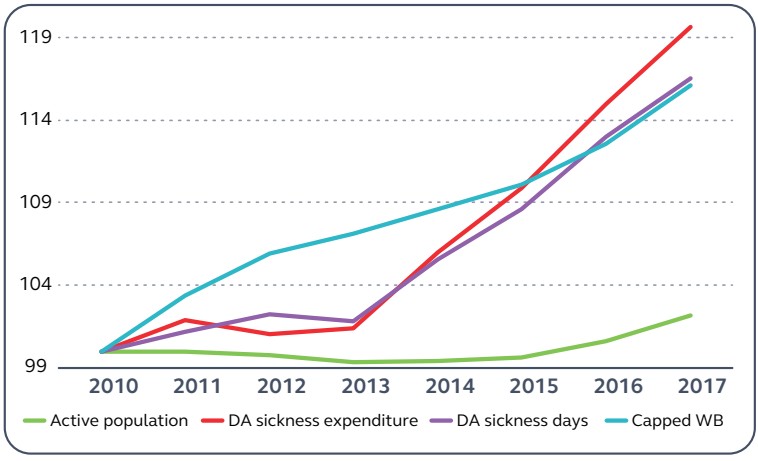
In 2017, expenditures on daily allowances reached €14.5 Bn for mandatory basic social security schemes. The general scheme covering employees in the private sector concentrates 90% of such expenditures to a total of €12.9 Bn, including €7.4 Bn for illness, €2.9 Bn for AW/OD and €2.6 Bn for maternity.

Expenditures on daily allowances for illness are particularly dynamic. In the general scheme, they increased by an annual average of 4.2% between 2013 and 2017.

This rate of increase exceeds that of the ONDAM (annual average of +2.1% over the same period) as well as of the wage bill capped at 1.8 x the SMIC (minimum wage), which constitutes the compensation base (annual average of +2.2%).

Daily allowances: increasing expenditures on health risk cover, a need to control absences from work

Evolution of expenditures daily allowances for illness, number of days compensated, and wage bill capped at 1.8 SMIC (2010-2017, base 100 in 2010)



Source : Cour des Comptes, based on data from INSEE, DSS and CNAM.

The disparity between the increase in expenditures compensating absences from work due to illness and the wage bill capped at 1.8 x SMIC (annual average of +2 points between 2013 and 2017) impacts *Assurance Maladie*'s financial balance, as it is largely funded by levies on wage income.

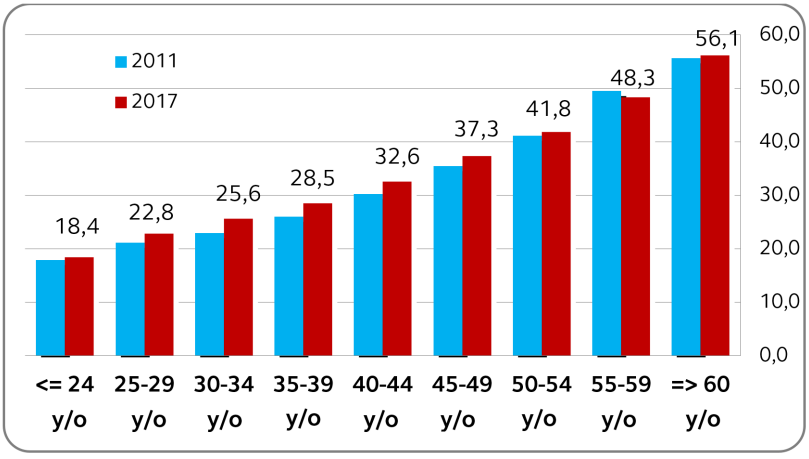
It expresses the increase in the percentage of insured parties compensated for at least one absence from work, the average number of absences per insured party and, in particular, the average duration of absences (which increased from 31.2 to 33.5 days between 2013 and 2017: +7.4%).

Expenditures on compensating absences from work due to illness are increasingly concentrated on long absences. In 2017, absences longer than six months accounted for 6.2% of absences but 44.6% of expenditures, as against 5.5% and 43.2% respectively in 2011.

The increase in the employment rate for older workers, under the effect of successive pension reforms, helps explain the increase in the average duration of absences. But it is by no means the only explanation: the average duration of absences has increased for all age brackets with the exception of 55-59 y/o.

Daily allowances: increasing expenditures on health risk cover, a need to control absences from work

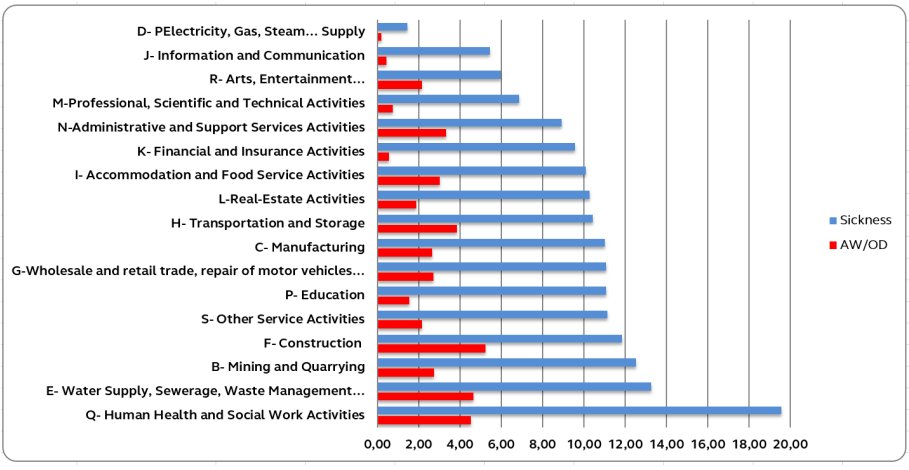
Average duration of absences due to illness by age bracket (general scheme, in number of days, 2011 and 2017)



Source : Cour des Comptes, based on CNAM data.

Numbers and durations of absences from work differ considerably from one activity sector to another. On average, each employee in the human health and social action sectors took almost 20 days' sick leave in 2016, as against just over 11 days for employees in industrial and building sectors. In 2016, 23% of expenditures were connected with mental health pathologies, which are likely to be activated or exacerbated by employees' working conditions.

Average number per employee of days off work due to illness or accidents at work/occupational diseases (AW/OD) (in 2016)



Source : Cour des comptes

Any territorial disparities observed are not only the result of differences in the population's age structure or prevalence of pathologies. Some of them also express differences in physicians' prescribing practices.

Reducing absences from work due to illnesses resulting from working conditions

Following initial experiments, the *Assurance Maladie* Medical Service should extend exchanges instigated with companies in which there are large numbers of absences from work. Such exchanges would help improve companies' knowledge of their employees' reasons for taking days off (without individual details) and provide them with data for comparing their own situations with those of companies of similar size in the same activity sector.

In addition, a new financial incentive[7] for companies might well be instituted, by transfer to employers of a part of the cost of compensating work absences of less than six months currently borne by *Assurance Maladie,* provided that no evidence of discriminatory recruitment has been found.

In order to reduce number of short-term absences from work, a mandatory waiting day, not compensated by employers or insurers, might well be instituted for employees, as is already the case in the civil service.

Such a measure would send employees, employers and prescribing physicians a further signal regarding the need to control frequency of absences. In order for it to have the desired effect, it should be accompanied by an appropriate communication to insured parties on the part of the public authorities.

Recentring prescribed work absences on their medical purpose

There needs to be increased supervision of over-prescribing physicians by the *Assurance Maladie* medical service. According to the CNAM, the Medical Service's 2016-2017 action campaign only led to savings of €59.1 M. Although the National Health Insurance Fund (*Caisse nationale de l'Assurance Maladie* – CNAM) considers between 700 and 1,000 physicians to be "over-prescribers" compared with their colleagues, only 47 reduction goal procedures (*mises sous objectif* – MSOs) and 39 prior approval procedures (mises sous accord préalable – MSAPs), the only measures that really act as constraints, were implemented in 2018.

Benchmark sheets drawn up by *Assurance Maladie* and approved by the High Authority for Health (*Haute*

[7] Employers supplement allowances paid out by Assurance Maladie, either directly, as required by law, for most employees (pursuant to the 1978 law on "Mensualisation" – i.e. payment of a fixed monthly wage no matter how many days there are in the month) or via private complementary insurance schemes (pursuant to branch or company agreements).

Autorité de Sante – HAS), which set out indicative durations for work absences for standard cases, only cover 15% of expenditures on compensation. They should be extended to cover all types of common pathologies.

Provided for by the Act of 24 July 2019 bearing on the organisation and transformation of the health system, and subject to certain exceptions yet to be defined, compulsory dematerialisation of sick-leave prescriptions by physicians should be mandatorily accompanied by their reasons for such prescriptions, including the medical cause for the absence and the duration prescribed when it does not coincide with benchmark sheets.

Exceeding absence durations provided for in benchmark sheets without adequate justification should lead to *Assurance Maladie* reducing the remuneration of public health goals (rémunération sur objectifs de santé publique – ROSP) paid to over-prescribing practitioners.

As regards non-LTI employees, the sick-leave compensation reference period should be reduced to two years and the maximum compensation period currently set at 360 days reduced in consequence. Risks of employees' occupational deintegration are foreseeable in the first six months of absence, so much so that the three-year reference period may lead to situations prejudicial to return to work.

Reducing benefit payment periods

The average waiting period for payment of the first non-subrogated sickness benefit (i.e. not advanced by the employer on behalf of Assurance Maladie) was still 27.7 days in 2017. With *Assurance maladie* being unable to commit to a deadline for reimbursing employers, subrogation is stagnating (33.6% of expenditures on sickness benefits in 2016), although it enables insured parties to be compensated more rapidly.

The mandatory dematerialisation of physicians' sick-leave prescriptions introduced by the abovementioned Act of 24 July 2019 should promote reduction of benefit payment waiting periods.

Reducing unjustified or avoidable expenditures connected with benefit management conditions

The benefit management procedures and tools implemented by *Assurance Maladie* show evidence of costly weaknesses.

In 2018, 12% of new allocated daily allowances contained financial errors at the expense of insured parties or, more often, *Assurance Maladie* itself.

Such errors cost *Assurance Maladie* a net total to the tune of €300 M. They result from a lack of automated consistency checks on data declared

Daily allowances: increasing expenditures on health risk cover, a need to control absences from work

by employers and insured parties, inadequate knowledge of regulations (which are always complex) on the part of funds during manual stages in allocation of allowances, and absence of automated recovery of all data on employees with more than one simultaneous or successive employer. Progress on this last point is set to be made as from 2020.

Assurance Maladie also makes potentially avoidable expenditures on sick-leave benefits, estimated only partially at almost €0.5 Bn a year by the CNAM. They are attributable to the sometimes abnormal extension of benefit payment periods due to poor coordination of *Assurance Maladie* medical and administrative services' activities.

Actions undertaken by the CNAM with a view to improving internal management practices have succeeded in significantly reducing such expenditures. Further progress is expected from extension of these actions and regulatory changes that may help reinforce them.

In addition, the CNAM needs to improve the medico-administrative procedure for compensating work absences, by setting action deadlines that have to be complied with by medical and administrative services for each step in the procedure.

Assurance Maladie and the URSSAF network should also define IT tools and management procedures enabling crosschecking of information declared by employers in their monthly Nominative Social Declarations (DSNs), which provide the basis for employees' entitlements to benefits as well as contributions for which employers are liable.

Recommendations

9. Provide better support to physicians on prescribing sick leave, via indicative durations for all common pathologies, any exceedance of which would have to be justified by prescribers, and adapt totals of the ROSP paid to physicians whose prescriptions prove to be excessive (CNAM and HAS).

10. Introduce a mandatory waiting day applicable to employees in order to better control repeated short-term absences from work, accompanying the measure with an appropriate communication to insured parties and prescribing physicians (Ministry responsible for social security).

11. In order to reduce risks of non-LTI employees' occupational deintegration, reduce the sick-leave compensation reference period from three to two years and adjust the maximum compensation period accordingly (Ministry responsible for social security).

12. Provide more individualised support during the first quarter year of absence in order to promote return to work, in all cases where a risk of long-term disengagement can be identified (Ministry responsible for social security, and CNAM).

13. Continue with reduction of unjustified or avoidable expenditures made by Assurance Maladie due to daily allowance management conditions:

- by improving the medico-administrative procedure involved, setting action deadlines that have to be complied with by medical and administrative services for each step in the procedure;

- by exploiting data declared in DSNs in order to better ensure conditions for entitlement to allowances, their consistency with declared contribution wage bases, and the accuracy of calculation of allowances (Ministry responsible for social security, and CNAM).

4 Disability pensions: essential modernisation to ensure improved support to insured parties

Disability pensions are social security contributory benefits paid to insured parties whose ability to work has been substantially and permanently reduced as the result of a non-work-related accident or illness.

In 2017, €7.4 Bn of benefits was paid out to 820,000 beneficiaries by mandatory basic social security schemes. With supplementary coverages included, the total amount paid out in disability pensions the same year was in excess of €10 Bn.

Disability pension holders have other related rights: award of a retirement pension at the full rate when they reach the legal retirement age, even if the insurance duration condition has not been met; validation of quarters with respect to disability periods compensated; and 100% reimbursement of most healthcare costs by *Assurance Maladie*.

Disability has long been covered by a scheme that has changed little despite changes in the economic and social environment. In many respects, it is a "blind spot" in our social protection system, and there are inconsistencies in the organisation of its management. Whatever changes may be made to it, the human and financial issues involved in disability require more active management of the risk, aiming to provide better assistance in getting pension holders back to employment if their state of health permits it.

A risk that continues to be segmented by profession

In France, disability insurance was originally introduced for public officials, in the form of early retirement pensions. *Assurance Maladie* introduced it for private sector employees in 1945.

Its history helps explain why disability coverage, although universal, is still segmented into a score of schemes very much depending on profession.

While *Assurance Maladie* benefits have become increasingly unified and establishment of a universal pension system is in the pipeline, there is also a need for harmonising definitions of, rules on and ways of calculating disability benefits.

Disability pensions: essential modernisation to ensure improved support to insured parties

Poorly known, heterogeneous levels of employee compensation

For one and the same category of insured parties (classified depending on the probability of their being able to return to employment), levels of compensation vary depending on whether or not supplementary coverage is involved.

Supplementary coverage of disability and death risks is mandatory for managerial staff at interprofessional level. However, coverage for non-managerial staff depends on branch or, failing that, on which companies are concerned. According to the December 2017 CREDOC/CTIP Barometer, 61% of employees have supplementary coverage (as against 47% in 2013).

When pension holders' resources fall below a specified sum, they may be complemented by a solidarity benefit funded by the State: the Supplementary Disability Allowance (*Allocation supplémentaire d'invalidité* – ASI).

The number of ASI recipients (69,900 in 2016) is steadily decreasing, as the allowance has not been increased above the inflation rate, unlike the minimum old-age pension and the Disabled Adults' Allowance (*Allocation aux adultes handicapés* – AAH).

The ASI is unlike other minimum welfare payments in that the maximum cumulative total of the disability pension and the ASI does not reach the resources ceiling at which this differential benefit stops being paid (€705.88 as against €723.25 for a single person in 2019).

Non take-up of the ASI has not been measured.

Effects of substitution of disability benefits with other risks

In some cases, pension holders' disabilities may be partially of professional origin (accumulation of non-occupational and sometimes undeclared occupational pathologies) or indirectly so (such as premature physical decline). Transfers of corresponding charges from the accident at work/occupational disease branch (AW/OD) to the sickness branch, which finances disability pensions, are not evaluated or compensated financially.

There are even overlaps between disability and handicap.

Although disability pensions and the AAH have different purposes and characteristics, less well-off pension holders can receive a differential AAH if they meet the required conditions. The Court estimates that 12% of disabled people collect a disability pension complemented by the AAH.

The reform of minimum welfare payments currently underway could provide an opportunity to merge the ASI with the AAH, with a view to unifying such payments, improving less well-off disabled people's situations and simplifying pension-holders' administrative procedures (they would no longer have to request the ASI and then the AAH when they meet the required conditions).

Disability pensions: essential modernisation to ensure improved support to insured parties

Taking account of its cost to public finances (the AAH now stands at €900 a month), any eventual merger or reconciliation of the ASI with the AAH would nonetheless need to be carried out gradually. Care must also be taken not to exclude ASI recipients who do not meet AAH conditions[8] from access to a minimum welfare payment.

Human and financial factors that need to be better recognised

Numbers of disability pension recipients increase as they approach legal retirement age, and then start decreasing at 62 y/o, the age they can retire with a full-rate pension.

On average, disability pension recipients, the majority of whom are now women, are in a worse state of health than other insured parties of working age and, when they retire, have a lower life expectancy than other retirees.

Expenditures on disability pensions are dynamic. In the general scheme (€6.2 Bn in 2018), they have increased by an annual average of 4.9% since 2011.

Such dynamics have largely been the result of the change in the legal retirement age brought about by the 2010 pension reform, which raised it from 60 to 62. Duration of pension payments has increased for retirees who, in the absence of reform, would have retired earlier. Furthermore, numbers of declarations of disability have increased, as some insured parties can no longer retire at the age of 60 and so make use of this particular mechanism.

In schemes covering employees and freelance workers, the increase in the legal retirement age alone has resulted in a 20% to 25% rise in numbers of pension holders and an increase in expenditures from €1.2 Bn to €1.5 Bn.

Preventing occupational and social deintegration

Disability does not rule out continuing with or going back to a job. In 2018, in the general scheme, over 70% of Category-1 pension holders (those deemed most likely to find employment, 25% of disabled people) had a professional activity of some kind. Although *Assurance Maladie* recognised them as being totally incapable of taking up employment, such was also the case with 24% of Category 2 pension holders (73% of all disabled people) and 9% of those in Category 3, who have need of a assistance from a third person in their daily lives (2%).

[8] Rules governing recognition of disability and handicap differ. In the general scheme, Assurance Maladie recognises an insured party's disability in the event of permanent and substantial loss of at least two-thirds of their capacity to take up employment, in whatever profession, suited to their capacities and paid over one third of a normal wage. The AAH is awarded (provided resource conditions are met) to people with at least 80% incapacity or with 50% to 79% incapacity when it results in substantial, lasting restriction of access to employment.

Assurance Maladie should improve medical and social monitoring of disabled people who are the least likely to find employment over the long term. Taking account of disability pension holders' frequently repeated requests for information, it should also work to facilitate all disabled parties' exercise of their rights.

In addition, the accumulated total of a disability pension and professional income may not exceed the total of the wage earned prior to cessation of work and declaration of disability. This threshold effect hardly acts as an incentive to return to a job, and penalises individuals who were in reduced or poorly paid employment prior to their declaration of disability. In order to provide better assistance in getting disabled people back to employment, the totals of pensions paid to them should be more gradually reduced in line with increases in their professional incomes.

Finally, the Social Security Code stipulates that disability pensions are temporary benefits. This being so, Category 1 pensions should be awarded for a defined period, at the end of which their recipients' state of health should be re-evaluated by the *Assurance Maladie* Medical Service. Such re-examination would enable assessment of whether or not the pension should be continued or suspended, or whether an insured party's category should be changed.

Improving the effectiveness of all medico-administrative disability procedures

According to medical officers, disability assessment practices adopted by the *Assurance Maladie* Medical Service are heterogeneous, a situation that leads to major territorial disparities. If they are to be homogenised, the CNAM will have to draft a mandatory national medical reference framework incorporating insured parties' employability. Thought should also be given to harmonisation of disability and handicap assessment criteria.

Disability pension recipients should also provide periodic declarations of their professional income (or resources if they are ASI recipients). Such declarations, which can lead to upward or downward revision of pensions, are inadequately audited, so encouraging errors and fraud. In order to ensure correct payment of pensions, *Assurance Maladie* should make use of data from the monthly resources base set up in early 2020 in the context of reform of housing aid.

Finally, there should be continued reduction of management costs, by extending the pooling of administrative management of disability among Primary Health Insurance Funds (*Caisses Primaires d'Assurance Maladie* – CPAMs) to new tasks, entrusting it to fewer funds (28 at present), and replacing IT tools, many of which are now obsolete. This would free up resources and so enable provision of more individualised assistance to disability pension recipients.

Recommendations

14. Encourage a return to the labour market on the part of individuals recognised as disabled but deemed the most likely to find employment, by replacing the cumulation rules currently in force with a mechanism that progressively reduces a pension as professional income increases, so that all work income is expressed by a supplement to resources (Ministry responsible for social security).

15. Organise a Category 1 pension service of fixed, renewable duration, in accordance with insured parties' ages and states of health, and provide targeted assistance with return to employment; improve tools enabling identification of pension holders who require special monitoring at medical, social and professional levels (Ministry responsible for social security, and CNAM).

16. Provide disability assessment with a national reference framework binding on local branches of the Medical Service, and give thought to assessment of disability and handicap based on a common reference framework (Ministry responsible for health, and CNAM).

17. Extend remodelling and pooling of risk management and implement systematic automated checking of professional income and resources declared by disability pension and ASI recipients, based on data in social security bodies' monthly resources databases (CNAM).

5 Early retirement: numerous, unequally justified mechanisms; a need for redefinition

In the strict sense of the term, early retirement means retirement before the statutory pensionable age, which is currently 62 for insured parties born in and after 1955.

By extension, the notion also covers retirements at the statutory age but which benefit from full-rate pensions with no conditions as to required age or insurance duration (whereas normally the full rate is in principle awarded, with no duration conditions, five years after the statutory age is reached, i.e. at age 67).

The Court has made an unprecedented assessment of seven of the main mechanisms for retirement under conditions derogating from age and insurance duration requirements: long careers, unfitness (whether or not replacing a disability pension), civil service "active" categories, permanent incapacity, early retirement for workers with disabilities (retraite anticipée des travailleurs handicapés – RATH), the occupational risk prevention account (compte professionnel de prévention – C2P) (arduous working conditions), and phased retirement.

In 2017, the seven mechanisms examined by the Court were responsible for nearly 400,000 early retirements, almost half of all retirements by derogation of the statutory age and the required insurance duration.

Their impact on the pension system's financial situation (close to €14 Bn in supplementary expenditures in 2016) calls for more effective ranking of such mechanisms' priorities.

Numerous derogation mechanisms

Three mechanisms are responsible for the majority of retirements and expenditures.

Instituted in the context of the 2003 pension reform for all pension schemes; the long-career mechanism (accounting for over 250,000 retirements and €6.1 Bn in supplementary expenditures) enables insured parties who have completed the required insurance duration for the full rate to retire before the age of 60 if they started work before they were 16 and before the age of 62 if they started work before they were 20.

"Active" categories (31,000 retirements and €3.3 Bn in supplementary expenditures) enable a percentage of employees in the three civil services to retire five and sometimes even ten years early (for "super-active" categories), due to the dangerousness of the positions they hold or the high accident rate characteristic of certain jobs.

Early retirement: numerous, unequally justified mechanisms; a need for redefinition

Unfitness (130,000 retirements and €1.7 Bn in supplementary expenditures) entitles disability pension holders and employees declared unfit to work by the Assurance Maladie Medical Service to a full-rate pension once they reach the statutory pensionable age, even if the insurance duration condition has not been met.

The four other mechanisms examined are designed to take account of arduous working conditions (occupational risk prevention account – C2P), state of health (permanent incapacity and early retirement for workers with disabilities – RATH) and career (phased retirement).

Multiple evolving and unequally verified purposes

Every pension reform since 2003 has seen the creation of new derogation mechanisms or modification of those already in force. Four of the seven mechanisms examined were created after 2003 and five have been substantially modified since that year. The long-career mechanism has been modified four times since its creation in 2003 (in 2008, 2010, 2012 and most recently 2014).

Counterbalancing measures designed to raise the average retirement age, each reform has created or extended compensatory mechanisms aiming to give concrete expression to concerns regarding social justice and ensuring balanced reforms.

Several mechanisms have very much the same objectives, but with disparate levels of benefit and often without any clear justification for the difference in treatment of insured parties that result from them.

For example, potential or proven impacts of work on state of health are taken into account by five mechanisms, but in accordance with three distinct approaches: length of career for long careers; nature of tasks carried out at work for the C2P and "active" categories; and deterioration of state of health for unfitness and permanent incapacity.

Some mechanisms are particularly complicated. The list of jobs included in "active" categories has not been updated for over thirty years for members of the National Pension Fund for Local Community Civil Servants (Caisse Nationale de Retraite des Agents des Collectivités Locales – CNRACL), a state of affairs that leads to major application problems.

Finally, although the need to compensate for disparities in life expectancies has often been highlighted in support of early retirement mechanisms, available data does not confirm such disparities, on average or as yet, with regard to "active" categories and long careers. There is no significant difference in the average life expectancy at age 60 between "active" categories (average of 26.7 years) and "sedentary" categories (average of 27.6 years) in the three civil services. The average life expectancy at retirement for beneficiaries of the long-career mechanism does not seem to be any lower than for other insured parties.

Early retirement: numerous, unequally justified mechanisms; a need for redefinition

Mechanisms that now account for almost half of all retirements

In the general scheme for private sector employees, the percentage of retirements that fall within the scope of the Court's investigation has almost doubled, increasing from 24.4% in 2011 to 46.1% in 2017. In civil servants' schemes, it reached 56.2% in 2017, as against 37.7% in 2011, due in particular to increases in retirements from the hospital civil service.

This increase in numbers of retirements with full-rate pensions under conditions derogating from age and insurance duration requirements contributes to the low activity rate in the 55-64 y/o age bracket in France (55% in 2017 as against an average of 61% in the European Union). It mainly reflects the increase in early retirements due to long careers.

The flexibility measures applied to the long-career mechanisms, in particular by the Decree of July 2012, led to a sixfold increase in such retirements between 2009 and 2017, rising in the general scheme from under 30,000 in 2009 to almost 180,000 in 2017.

Despite statutory changes that have closed this mechanism to new recipients in exchange for career upgrades (teachers, nurses, etc.), the number of active-category civil servants has only slightly decreased.

Expensive mechanisms that have undercut the effects of retirement-age reforms

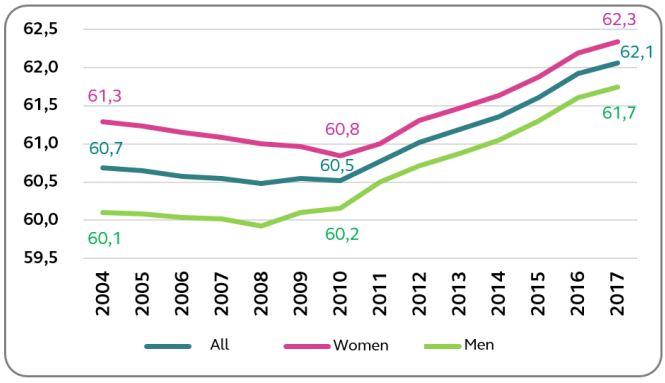
Over the last few years, despite a reduction in individual benefits obtained from early retirement mechanisms, these latter, the long-career mechanism in particular, have been partly responsible for reducing the effects of pension reforms regarding the statutory pensionable age.

Following creation of the long-career mechanism, the prevailing age[9] of retirement started off by going down. It started to rise again as from 2010, reaching 62.1 in 2017.

[9] i.e. the average age of a fictional generation with the same proportion of retirees at each age as that observed over the course of the year.

Early retirement: numerous, unequally justified mechanisms; a need for redefinition

Prevailing age of retirement (all schemes, 2004-2017)



Source : DREES, EIR, EACR and ANCETRE model; INSEE, Demographic Profile 2016

Since 2010, the increase in retirement age has been slowed down by the increase in early retirements, under the effect of which the number of retirees in each age bracket preceding the statutory retirement age has also increased: one in three people at end 2017 (with a statutory retirement age of 62), as against one in five at end 2010 (with a statutory retirement age of 60).

Early retirements generate supplementary expenditures corresponding to sums paid out to their beneficiaries between the dates on which they retired and the dates they would have retired if possibilities of early retirement had not existed.

The cost burden of early retirements that fall within the scope of the Court's investigation is becoming heavier. In 2016, they were responsible for almost €14 Bn in supplementary expenditures, 5.2% of all expenditures on benefit entitlements in basic and supplementary pension schemes, as against about 3% in 2012.

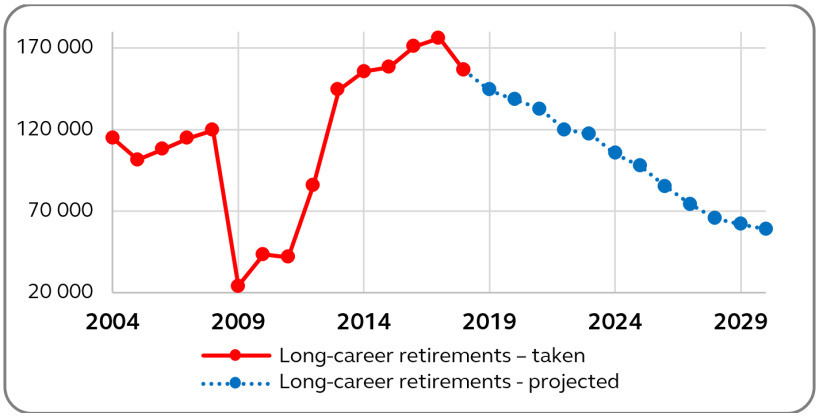
The long-career mechanism alone accounted for 16.9% of the increase in expenditures on benefit entitlements under the general scheme between 2012 and 2017 (€2.2 Bn out of a total of €12.8 Bn).

Mechanisms that need reconsidering given their impact on the pension system's financial situation

Control of pension expenditures requires control of flows of early retirements.

In 2018, the flow of early retirements after long careers went into reverse in the general scheme under the effect of the progressive increase in the duration of insurance required in order to obtain a full-rate pension, pursuant to the provisions of the 2014 pension reform. The decrease in this particular flow is likely to continue, although it is unlikely to return to its 2009 until the mid-2030s.

Flow of "long-career" early retirements in the general scheme (2004-2030)



Source : CNAV

It is essential that this projected drop in the number of "long career" early retirements actually happens. With this in view, conditions for such retirements need to be tightened up, or at least stabilised.

Moreover, insured parties currently have to make an immediate decision on whether to retire or keep on working. Phased retirement, which enables them to receive a part of their pensions while exercising a part-time activity, only concerns a relatively small number of retirements, although numbers are increasing significantly (10,000 in 2017 as against 2,500 in 2012).

In the context of future changes in the pension system, modes of gradual transition to retirement should be prioritised over total termination of professional activity.

There is also a need to continue with re-examination of the range of professions included in "active" categories and the duties performed within each profession. In order to facilitate acceptance of such re-examination, it might only have a binding effect on new insured parties (as was the case with teachers in 2003 and nurses in 2010).

Finally, the contribution rates that fund C2P and permanent incapacity should be adjusted with a view to encouraging employers to step up their efforts to prevent occupational risks, which result in early retirements resulting from the two mechanisms.

Levers of action in the context of future changes in the pension system

- Unlike previous reforms, prioritise ways of gradual transition to retirement over immediate total termination of professional activity (Ministry responsible for social security).

- Stabilise conditions for access to the "long career" mechanism in order to ensure that the projected reduction in the flow of consequent early retirements actually happens with no change in legislation (Ministry responsible for social security).

- Re-examine the range of professions included in "active" categories and the duties performed within each profession that justify award of these advantages (Ministries responsible for the budget, the civil service and social security).

Recommendations

18. Monitor and analyse changes in all early retirement mechanisms on a regular basis (numbers and characteristics of beneficiaries, costs, effects of substitution between mechanisms; impacts on their economic, social and health environments) in order to improve their management (Ministry responsible for social security, CNAV).

19. Make employers accountable with regard to prevention of occupational risks and arduous working conditions responsible for early retirements, by financing all expenditures on retirements due to permanent incapacity and the occupational risk prevention account by contributions distinct from AW/OD contributions, adjusted for each activity field at the origin of the retirements concerned (Ministries responsible for social security and the budget).

20. Simplify procedures carried out by disabled workers by providing assessments of the disability rate at the time of recognition of the status of disabled worker (reconnaissance de la qualité de travailleur handicapé – RQTH) and by extending access to the National Old Age Insurance Fund's (Caisse nationale d'assurance vieillesse – CNAV) committee that validates periods with no supporting documents to 50% disabled individuals (Ministry responsible for social security).

6 Organised transport in healthcare and medicosocial sectors: issues requiring recognition and regulations that need remodelling

Excepting emergencies, patients may be transported by ambulance, light medical vehicle (*véhicule sanitaire léger* – VSL) or taxi from their home to a healthcare facility or doctor's surgery, or between facilities.

The term "medicosocial transport" refers to travel to and from facilities and services for elderly and disabled people.

High, dynamic expenditures on transport of patients

Expenditures on organised transport of patients are estimated at €5 Bn for 2017. They included €4.7 Bn billed by transport companies or reimbursed to patients by *Assurance Maladie* in respect of the 87 million journeys made by 5.8 million patients. An additional total of over €230 M was paid by public health facilities out of their own budgets.

In 2017 *Assurance Maladie* financed 93.1 % of expenditures (excepting facilities' own budgets), showing a slight increase in percentage over time. This very high level is largely due to the fact that 90% of expenditures are on behalf of patients with long-term illnesses (LTIs), for whom *Assurance Maladie* assumes all costs, including the user fee.

The level of public funding of patient transport expenditures is considerably higher than in comparable countries (a per capita average of €63 in France as against €16 in Germany in 2013).

Expenditures covered by *Assurance Maladie* are highly dynamic (yearly average of +4.1% for the employees' general scheme between 2011 and 2017).

A third of the rise in expenditures is due to increases in prices and VAT over the course of the period. The other two thirds reflect the increase in numbers of journeys and distances covered, along with evolutions in types of vehicles most used.

The share of the most expensive means of transport used for such journeys has increased (taxis, 45.7% in 2017) or remained stable (ambulances, 22.4%), while that of the least expensive (VSLs, 31.9%) has decreased. Use of private vehicles reimbursed by *Assurance Maladie* continues to be only marginally significant.

The rapid increase in expenditures cannot only or even mainly be blamed on reorganisations of hospital healthcare provision.

In fact, average expenditure levels differ considerably between highly urbanised *départements* (a per capita average of €35 in Loire-Atlantique in 2017 as against €78 in Bouches-du-Rhône). The relative shares of the various means of transport employed plays a determining role in this respect.

Expenditures on medicosocial transport still poorly understood

Although expenditures on medicosocial transport are a major concern, they are not monitored as a whole. The Court estimates them as being in excess of €1 Bn a year.

Such expenditures are mainly funded by medicosocial facilities out of their own budgets.

Ways in which they are assumed differ, however, depending on type of facility and type of transport.

In principle, medico-educational institutes should use their own budgets to pay for collective and individual transport connected with reception and provision of care. In other cases, *Assurance Maladie* assumes responsibility for the cost of journeys (medico-psychological centres with user charges; at 100% for medico-psycho-pedagogical centres and early medicosocial action centres, following prior agreement by the Medical Service).

Some types of medicosocial transport are not paid for out of public funds, however: placement in a long-term care unit or care home for dependent elderly people (établissement d'hébergement pour personnes âgées dépendantes – EHPAD), and individual/group sessions for children under the wing of special education and home care services.

Inadequate regulation

Provision of patient transport is inadequately supervised. It is true that there have been vehicle quotas per *département* since 1995, but they only cover ambulances and VSLs, not approved taxis. In addition, such quotas are not updated on a regular basis and are exceeded in 81 *départements*. The 2015 Decree that enables CPAMs to refuse to approve new taxis when supply is overabundant has not always been implemented.

Price changes are inadequately controlled. Prices setting is divided between ambulances and VSLs on the one hand and taxis on the other, as well as between national and départemental levels. Since the early 2000s, prices have increased more rapidly than inflation for taxis and VSLs, and to a similar extent for ambulances. The memorandum of understanding signed between Assurance Maladie and taxi company representatives in late 2018 marks a change for the better, however,

by partially separating increases in fares charged by approved taxis from those set by prefectural orders.

Attempts at making prescribers more accountable have little effect. Actions targeting private practitioners evidencing high rates of transport prescription (visits by *Assurance Maladie* delegates) are largely ineffective. In healthcare facilities, absence of identification of prescribing physicians (even though mandatory) hinders this type of approach. Tripartite contracts signed between facilities, Regional Health Agencies (*Agences Régionales de Santé* – ARSs) and health insurance funds with the aim of controlling expenditures have little demonstrable effect.

There is highly inadequate monitoring of the quality of patient and medicosocial transport. Patients' complaints and reports (when they are made) highlight cases of transporters failing in their duties to the detriment of treatment quality.

Continuing with transfer of transport expenditures to healthcare facilities' budgets

Expenditures on patient transport are better controlled when healthcare facilities where it is prescribed take responsibility for them out of their own budgets than when *Assurance Maladie* reimburses them to transport companies or patients.

In fact, expenditures on transport financed by public health facilities out of their own budgets decreased from €255 M to €235 M between 2012 and 2017. In the medicosocial sector, integration of the majority of transport expenditures into institutions' budgets (they are often the 2nd expenditure item after staff) helps keep them under control.

Since October 2018, pursuant to Article 80 of the 2017 Social Security Finance Act, healthcare facilities' budgets have included expenditures on inter-institution journeys that had not previously been their responsibility (making a transfer of €290 M in expenditures). Despite the difficulties caused by inadequate preparation, the reform has been implemented.

Healthcare facilities' budgets should incorporate all patient transport expenditures resulting from their own prescriptions (as against a current 15%). Expenditures connected with dialysis sessions (€0.7 Bn in 2017) are a priority concern.

Re-medicalising patient transport

Taking account of the combination of possible reasons for reimbursement of costs and exemption from user fees and fixed charges (€2 per journey and €4 per return journey), there are no fewer than 140 different situations as regards levels of reimbursement of patient transport by *Assurance Maladie*.

Organised transport in healthcare and medico-social sectors: issues requiring recognition and regulations that need remodelling

There are inconsistences in the rules governing reimbursement of such costs. For example, in principle, transport of a patient out of an emergency department is not reimbursed unless it is by ambulance, the most expensive means of transport.

Rules should be simplified so as only to target reasons to do with a patient's incapacity or disability, attested by a medical prescription.

In healthcare facilities, the medical nature of transport prescriptions should be reasserted, through systematic use of electronic signatures, or alternatively by delegation of prescription to advanced practice nursing staff.

In order to make insured parties more accountable, they could be required to bear a greater share of fixed charges paid by *Assurance Maladie* specifically for transport[10].

Organising transport more coherently

As action on the part of the various government agencies concerned is currently largely uncoordinated, transport by ambulance and VSL, transport by approved taxis and medicosocial transport should be placed under unified operational management at national and local level alike.

The possibility of *Assurance Maladie* almost systematically reimbursing journeys of up to 150 kilometres should make room for rules adjusted in accordance with degrees of provision of care as regards local, referral and reference healthcare facilities. Degrees of provision of medicosocial services should also be taken into account in budgetary negotiations between ARSs and the institutions concerned.

Better matching of vehicles to needs should also be ensured, limiting use of ambulances when it is not necessary. In particular, transporters specialising in the transport of persons with reduced mobility should be authorised to take disabled people to their care facilities.

[10] Fixed charges are currently capped at €50 per year per insured party. This sum includes charges for transport, paramedical actions and medicines.

Combating irregularities and fraud at the expense of *Assurance Maladie*

The principle of medical prescription prior to transport is seldom complied with: 33% of journeys are prescribed the same day, and an undetermined number are actually prescribed retroactively.

Absence of approval (of vehicles and/or staff), unlawful exercise of the activity, invoicing for non-existent journeys, false invoicing and invoicing noncompliant with prescription or delivery are all reasons for irregularities or fraud on the part of transport companies.

Dematerialisation of prescriptions needs to be universalised, including in institutions, in order to reduce the various types of irregularities and fraud. Electronic invoicing by transport companies should also be universalised, so as to provide *Assurance Maladie* with data enabling prevention and detection of certain types of irregularities and fraud; as regards taxis, this method of invoicing is only at an experimental stage.

Recommendations

21. Make physicians fully responsible for assessing the need for medical transport, by basing such need legally on a patient's incapacity or disability alone, and provide for the possibility of delegating prescription to advanced practice nursing staff (Ministry responsible for health, and CNAM).

22. Gradually transfer all expenditures on transport to the budgets of the healthcare facilities that prescribe it; define new steps to this effect, starting with dialysis sessions (Ministry responsible for health, and CNAM).

23. Make patients accountable by instituting a specific annual ceiling for fixed charges applicable to their transport, distinct from the ceiling that would continue to apply to paramedical actions and medicines (Ministry responsible for health, and CNAM).

24. Update the quota system for medical vehicles by including approved taxis and basing it on assessment of how well local needs are met in the areas involved (Ministry responsible for health, and CNAM).

25. Decompartmentalise patient and medicosocial transport, in particular by authorising transporters specialising in transport of persons with reduced mobility to take disabled people to their care facilities (Ministry responsible for health, and CNAM).

26. Universalise dematerialisation of medical transport prescriptions, in healthcare facilities in particular, in order to limit numbers of prescriptions issued after journeys have taken place (Ministry responsible for health.

27. Place the three medical transport sectors, approved taxis and medicosocial transport under unified operational management, at national and local level alike (Ministry responsible for health).

7 Acts and consultations outside hospital settings: an activity to integrate into definition of the healthcare offer

External acts and consultations (*actes et consultations externes* – ACEs) are dispensed by salaried physicians, usually at public or private non-profit-making healthcare facilities.

They differ from private practice consultations in that they are carried out at healthcare facilities, as well as from hospital sessions and stays, including outpatient medicine, due to their mostly being financed in line with prices applicable to private practitioners.

An activity inadequately monitored despite the significant financial stakes involved

In 2016, 22.5 million patients benefited from external acts or consultations, including 16.9 in non-emergency situations. For the medicine-surgery-obstetrics (MSO) sector, the number represents some 37.8 million medical consultations, not including emergencies, in addition to the 332.1 million consultations carried out in private practitioners' surgeries.

In 2017, ACEs were responsible for €4.2 Bn in MSO health insurance expenditures, 27% of which was for emergencies.

Expenditures on ACEs reimbursed by *Assurance Maladie* are dynamic. Their increase (an annual average of +4.8% between 2013 and 2017) has substantially exceeded that of corresponding private practice items, resulting in increasing diversion of expenditures on medical care and biological analyses in the direction of hospitals. Nonetheless, factors contributing to the evolution of ACE expenditures are yet to be fully understood.

ACEs also usually constitute a "blind spot" in hospitals' management of their activities. Even so, the ACE activity is considered as loss-making by its very nature: it employs hospital resources (human, medico-technical, etc.) to carry out procedures remunerated at the same level as a private practitioner.

Finally, ACEs are a side of hospital activity little analysed or monitored by the Ministry responsible for health at national level or by ARSs at regional level, even though they involve significant issues with regard to organisation and access to treatment.

Acts and consultations outside hospital settings: an activity to integrate into definition of the healthcare offer

Improvement required in healthcare facilities' organisation of ACE activities

Most healthcare facilities rationalise spatial organisation of ACEs by grouping all or part of the activity in areas separate from those devoted to hospitalisation. However, efforts made to better structure the stages in outpatient pathways have met with less success.

"Short pathways" for non-serious cases should be universalised, along with direct admission channels to competent hospital departments without having to go through emergency departments, in particular for the elderly, in order to simplify care pathways and improve treatment quality.

Financial balancing of ACEs would appear difficult to achieve as things stand at present in most institutions, as prices are set in accordance with a non-comparable activity framework. However, healthcare facilities need to provide themselves with adequate tools for analysing their ACE activities and identify levers of organisation enabling them to approach financial balance.

Ensuring full reliability of ACE activity funding

After a great many delays (it was initially planned for 2009), individual invoicing (IIHE) of ACEs to *Assurance Maladie* is now on the road to universalisation. It should enable major progress in management for healthcare facilities and Assurance Maladie alike. With this in mind, the latter needs to step up automated checks of the consistency of ACEs billed to it by institutions.

As regards portions of expenditures borne by supplementary health insurance schemes and patients themselves, the Ministry responsible for health needs to ensure successful completion of the projects currently underway that aim to improve collection of such revenues and simplify patients' administrative pathways.

There are a number of uncertainties inherent in methods used by healthcare facilities to invoice daycare. A "boundary circular" (*circulaire frontière*) aims to specify cases that may give rise to invoicing of ACEs or stays (which are more profitable), but it dates back to 2010. After a long delay, its revision should be completed by the end of this year.

A role requiring better definition based on concerns regarding access to treatment and efficiency of hospital organisation

Public and private non-profit-making healthcare facilities' ACE offers are essentially the result of their own autonomous choices, whereas they should take better account of local issues with regard to organisation of and access to care.

In principle, the medical projects shared by the 135 territorial hospital groupings (groupements hospitaliers de territoire – GHTs) instituted by the Act on modernisation of the health system of January 2016 should include principles for ACE activities, in particular advanced consultations of hospital

practitioners in other healthcare facilities or private practices (health centres).

Yet only half the GHTs' shared medical projects tackle ACE activities at member public hospitals.

In addition, implementation of advanced consultations does not necessarily depend on territorialised analyses of patients' needs. However, such consultations may enable a widening of access to specialised medical consultations in hospitals in outlying areas and lead to scaling of care provided in institutions in accordance with the complexity of patients' situations and the care they require.

ARSs, which approve the agreements bringing GHTs into existence, should make certain that their medical projects include components relating to ACE, providing for implementation of advanced consultations adapted to the needs identified in the context of the regional health projects they are tasked with developing.

In addition, in the context of the "My Health 2022" Plan, the Government has provided for closer association of local healthcare services (medical in particular) provided by hospitals and private practices: creation of 400 general practitioner positions shared between ambulatory and hospital practice in priority areas; certification by 2022 of 500 to 600 local hospitals staffed by variable proportions of hospital and private practitioners; creation of some thousand regional professional health organisations (communautés professionnelles territoriales de santé – CPTSs) acting on their own initiative to bring together health professionals, and which, among other things, should improve access to unscheduled treatment.

As it stands at present, the role that ACEs are set to play in implementation of these new ways of associating hospital physicians and private practitioners, and the implications that increased involvement of private practitioners in CPTSs have for ACE provision are yet to be defined.

In this respect, when the private practice offer is inadequate in terms of quantity or quality, external consultations at hospitals, which, excluding emergencies, account for around 11% of all medical consultations in France, could usefully complement it. When it is plentiful and affordable, the hospital ACE offer may be of lesser use.

Recommendations

28. Systematically incorporate hospital ACE activities in definitions of public orientations on local organisation of and access to healthcare: regional health projects developed by ARSs, territorial hospital groupings' medical projects, public hospitals' multiyear contracts for targets and resources, and CPTS projects submitted to ARS approval (Ministry responsible for health, and ARSs).

29. Complement revision of the "boundary circular" on ACEs and hospital daycare with a rescript mechanism on application of hospital daycare prices (Ministry responsible for health, and Assurance Maladie).

30. Provide more effective support to healthcare facilities' exercise of their external activities by ensuring reliability of data on revenues and costs connected with such activities and recommending avenues for reversal of differences in costs compared with the most successful institutions of comparable size (Ministry responsible for health, Technical Agency for Information on Hospitalisation (*Agence technique de l'information sur l'hospitalisation* – ATIH), National Agency for Support to the Performance of Health and Medicosocial Facilities (*Agence Nationale d'Appui à la Performance des établissements de santé et médico-sociaux* – ANAP) and ARSs).

8 The policy on transplants: a fragile transplant chain that needs better organisation

5,781 organ transplants were carried out in France in 2018, over 60% of which were kidney transplants.

Transplants save lives and help improve others. They are the final choice in cases of terminal kidney, liver, heart, lung or pancreas failure.

In addition, transplants are far less expensive than dialysis in treating terminal chronic kidney disease (TCKD): in 2017, *Assurance Maladie* devoted an average of less than 14,000 euros each in annual expenditures on monitoring patients who had just had kidney transplants, as against over 62,000 euros on each patient's dialysis sessions.

Per se, development of transplants is therefore of importance to improvement of the healthcare system's efficiency. But there are also considerations of the efficiency of harvesting and transplant of the organs themselves to be taken into account.

Results that may be significant but which have difficulty in covering transplant needs

France's performances with regard to organ transplants are highly respectable at international level. In 2017, with 90.2 transplants per million inhabitants, it ranked 3rd in Europe, behind Spain and Belgium, improving on its previous position (in 2009, it only ranked 5th in Europe).

Development of transplants relies on a legal framework favourable to harvesting from deceased subjects (with their presumed consent), national organisation of the transplant chain managed by the Agency for Biomedicine (Agence de la Biomédecine – ABM) and plentiful financial resources provided by *Assurance Maladie* (prices in compliance with or even higher than costs, and flat rates in addition to prices, coming to a total of €337 M in 2017).

Nonetheless, the number of patients waiting for transplants (mainly of the kidney) is growing faster than that of transplants carried out. Consequently, conditions for access to transplants are deteriorating. Between 2012 and 2018, the number of patients waiting for transplants rose from 10,648 to 16,413 (+54.1%).

In addition, whether as the result of particular circumstances or more long-lastingly, numbers of organ transplants fell by 5.3% in 2018 (5,781 transplants, as against 6,105 in 2017). In particular, there has been a decrease in the harvesting of organs from brain-dead subjects (-4.8%).

The policy on transplants: a fragile transplant chain that needs better organisation

Unequal development of organ harvesting

With a view to improving on past results, the 2017-2021 Transplant Plan provides for 7,800 organ transplants being carried out in 2021, comprising 6,800 harvested from deceased subjects and 1,000 from living donors. These goals will be difficult to achieve.

There is no doubt that organ harvesting is widely accepted in our country. There were fewer than 360,000 names on the national refusal register for organ donation in mid-2019. Moreover, families' objections to harvesting from deceased subjects are in the minority (30% in 2018), although there are major geographical disparities (with 41.5% in Île-de-France and 54.5% on Reunion Island). The ABM should analyse the causes of such disparities, which are detrimental to availability of organs, and promote increased homogeneity of harvesting teams' practices when interviewing potential donors' families.

In addition, efforts put into finding brain-dead subjects (fewer than 4,000 out of 587,000 deaths in 2016) are not equally successful, while such subjects are few in number and there are major time constraints on harvesting. Teams in institutions authorised to harvest organs should have closer connections with emergency and resuscitation departments in order to better anticipate possible harvestings.

Organ harvesting from subjects whose heart function has ceased irreversibly (categories of subjects known as "Maastricht II and III") concerns a few hundred subjects and is seeing unequal progress.

There are currently obstacles to development of harvesting from living donors (611 transplants in 2017, mostly of kidneys). In particular, nephrologists and dialysis centres are unequally aware of this particular possibility, although they are in the best position to inform their patients on the interest of a family member donating a kidney.

Rebalancing organ supply and demand

In order to increase numbers of available organs, authorised harvesting categories have been increasingly extended, both in France and elsewhere, to elderly subjects and subjects suffering from certain pathologies.

However, such extension has failed to overcome the shortage of organs compared with needs. Transplants are the answer to increasing numbers of health problems. Numbers of patients eligible for transplants are also growing due to the extension of age limits, decreasing contraindications, and the longer life expectances of patients' suffering from chronic diseases. However, traditional harvesting sources are diminishing, due to the drop in numbers of deaths caused by strokes and road accidents.

Various levers should therefore be employed to improve organ harvesting numbers: continuation of extension of medical indications for harvestings and transplants; greater effectiveness on the part of teams specialising in identification of potential organ donors; homogenisation of practices on the part of teams tasked with interviewing

members of potential donors' families; and greater awareness-raising among nephrologists and the families of people suffering from chronic kidney diseases.

It is also important to better prevent pathologies at the origin of transplant needs, terminal chronic kidney disease in particular, through increased screening for kidney disease among diabetic and hypertensive people and better prevention of obesity.

Paying renewed attention to patients' equality of opportunity

Equality of opportunity among patients waiting for transplants is of key importance to the population's acceptance of organ harvesting.

This being so, the ABM should work to reduce disparities in nephrologists' practices with regard to registering their patients on the national list of patients waiting for kidney transplants.

The ABM also needs to improve the design of scores for allocation of organs in the light of specific studies on the results of algorithms currently employed.

Finally, the ABM and all institutions concerned should make a determined commitment to improving the reliability of data taken into account when calculating organ allocation scores for patients waiting for transplants. The ABM's periodical audits of compliance of information taken into account for calculation of organ allocation scores with medical records reveal frequent anomalies.

Stepping up supervision of all links in the transplant chain

In view of the risks attached to organ harvestings and transplants, the ABM should be firmer in requesting healthcare facilities to declare all significant incidents that arise.

With numbers of transplant patients and donors continuing to rise, mechanisms for monitoring their state of health should also be improved.

Lastly, the ABM should be quicker in identifying frequencies of transplant failures that might bear witness to abnormal risks to patients' health in certain institutions.

Employing allocated resources more efficiently

There is room for optimising use of resources allocated to organ harvesting and transplant activities.

Save for a few exceptions, organ transplants are performed in one or other of the 30 UHCs. Nonetheless, several of these institutions are less active than others in this field. With a view to promoting treatment quality and safety, transplant activities should be authorised in accordance with activity thresholds differentiated by organ.

Thought should also be given to more optimal location of analytical laboratories specialising in transplants, hematopoietic stem cells in particular.

Lastly, certain prices need to be revised, including those for analyses of bone marrow transplantation histocompatibility (some of which are 5 to 30 times higher than actual costs).

Recommendations

31. Analyse the causes for the regional disparities observed regarding objections to harvesting and develop actions designed to homogenise harvesting teams' practices when interviewing members of potential subjects' families (Agency for Biomedicine).

32. Increase numbers of harvestings by lending support to development and medicalisation of harvesting networks, stepping up action on training hospital coordination teams, increasing medical professionals' awareness and developing best-practice reference frameworks (Agency for Biomedicine, Ministry responsible for health, and High Authority for Health.

33. Implement a plan designed to secure transplant teams' practices and medical data on transplant patients, based essentially on a remodelling of data recording tools and procedures and formalisation of lines of responsibility, and further develop work on objectivation of organ allocation scores (Agency for Biomedicine).

34. Institute minimum activity thresholds per geographic site for the various organs transplanted (reiterated recommendation) (Ministry responsible for health.

35. Rationalise location of analytical laboratories specialising in transplants (Ministry responsible for health, and Agency for Biomedicine).

9 Medically assisted procreation: a need for improved efficiency

Medically assisted procreation (MAP) enables infertile people to bear children.

MAP may either be carried out by intrauterine artificial insemination or by in-vitro fertilisation (IVF) followed by transfer of the embryo to the uterus. It may be carried out with the gametes of the couple who want children or with those of a donor.

Leaving aside ethical questions that do not fall within its field of competence, the Court has focused on the organisation, operation, cost and results of France's MAP system, as it stands prior to the revision of the law on bioethics currently underway. As with other areas of treatment, MAP has efficiency issues that need to be better recognised.

A diversified offer, significant cost for *Assurance Maladie*

MAP procedures are carried out at public and private centres and laboratories and, as regards artificial insemination, by gynaecologists in private practice.

The offer is balanced between public and private sectors (apart from special activities mainly carried out in the public sector).

It provides comprehensive coverage adapted to all needs. A little over half of *all départements*, concentrating more than 70% of women between 20 and 39 y/o, are able to provide public and/or private sector in-vitro fertilisation. There is greater, more widespread provision of artificial insemination.

Couples requesting MAP are required to undergo a series of consultations and biological and clinical tests, along with a stay in hospital for oocyte retrieval where IVF is concerned. The care path is reimbursed at 100% by *Assurance Maladie* up until the woman's 43rd birthday.

The Court estimates that MAP cost *Assurance Maladie* a total of almost €300 M in 2016. The average cost of a birth resulting from artificial insemination was 7,088 euros, while that for a birth resulting from IVF was 13,849 euros (taking all methods together).

Medically assisted procreation: a need for improved efficiency

Results within the European average

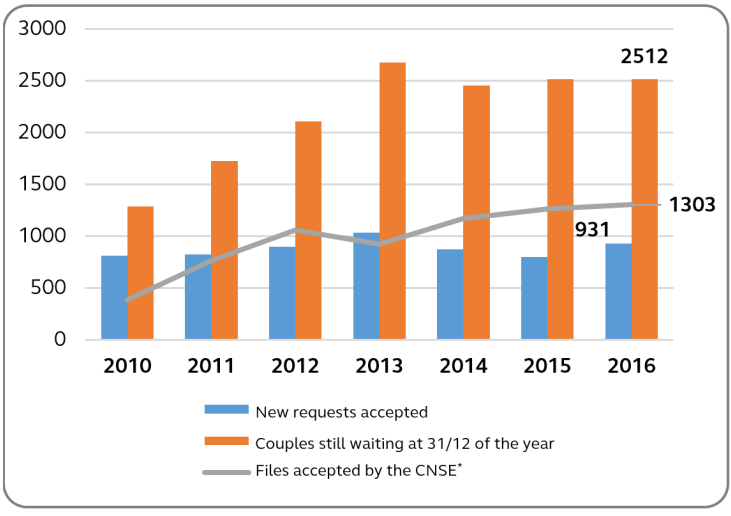
In 2017, 25,614 children were born as a result of MAP, which is responsible for a growing percentage of births: 3.3% in 2017, as against 2.7% in 2010 and 2% in 2002.

Independently of the revision of the law on bioethics currently underway, MAP's share in all births should continue to grow due to an upward trend in the average childbearing age.

Its IVF birth rates put France halfway between Europe's most and least successful countries in this field: in 2016, 20% of IVFs involving transfer of non-frozen embryos led to successful births in France, as against 28% in the United Kingdom and 16.9% in Italy. The disparity with British performance suggests that there is room for improvement in French clinico-biological centres.

Artificial insemination is the simplest, least invasive and least expensive form of medically assisted procreation. However, its birth rates per attempt are lower than for IVF: in 2016, 10.6% of intraconjugal artificial inseminations (IAIs) resulted in a birth. It is more widely provided as first-line treatment in France than in most other European countries. In 95% of cases it is intraconjugal, whereas in other countries it often involves donation of sperm by a third party.

Requests for MAP with donation of oocytes (2010-2016)



**National Centre for Care Abroad*
Source : ABM.

Percentages of multiple childbirths, an increased risk factor for mother and child alike and frequently associated with MAP, fell from 15.9% in 2013 to 11.7% in 2017 for IVFs, due to the growing share of single-embryo transfers in such procedures (50.6% in 2017, as against 35.9% in 2013). As regards artificial insemination, the multiple birth rate, 9.4% in 2017, has slightly decreased.

Medically assisted procreation: a need for improved efficiency

Mediocre results for MAP with donated gametes, despite recent progress

French law enshrines the principle of free-of-charge anonymous donation. Donor may not specify the recipients of their donations.

At present, sperm donations generally enable demand to be met within a year. However, the decreasing number of donors (404 in France in 2017) is a factor of fragility.

As regards donations of oocytes, there are not enough to meet national demand, despite it being possible since 2015 for childless people to donate their gametes. Childless donors are authorised to preserve a percentage of oocytes retrieved for use in eventual future birth projects, which has helped dynamise the oocyte offer (756 retrievals in 2017, a 40% increase compared with 2015, including 245 from childless women).

Hence, 1,069 couples benefited from oocyte donations in 2017, while 2,726 other couples were still waiting for a donation at the end of the year. Waiting periods, which may last from two to five years, are shorter if the couple presents a third person willing to donate oocytes to an anonymous third couple.

Recourse to crossborder treatment continues to increase as a result of the shortage of oocytes. Since 2014, there have been more new requests funded by *Assurance Maladie* than new patients treated in France. The dynamism of patient flows to other countries (Spain and the Czech Republic in particular) bears witness to the inadequacy of the national oocyte offer. The gap between supply and demand makes the goal of achieving national self-sufficiency in provision of gametes with no change in the law a highly ambitious one.

Research activities subject to major constraints

The legal regime governing research on reproduction and embryology is set by bioethical law. It is based on the principle that everything is prohibited that has not been expressly authorised by the Ministry responsible for health or its health agencies.

Before 2016, research on embryos was slowed down by major instability in its legal framework.

Complex authorisation procedures also apply to biomedical research and innovations in MAP. They do not encourage medical teams to seek out and test innovative procedures.

Despite the involvement of major research bodies and help from UHCs, French clinical research in the field of reproductive medicine enjoys little international visibility. It focuses above all on preservation of fertility; medically assisted procreation plays little part in it.

Improving MAP efficiency

As *Assurance Maladie* reimburses up to six insemination attempts, some practitioners continue such treatments after four failures, despite the risk of loss of opportunity for certain patients. The Agency for Biomedicine should analyse the usefulness of recourse to artificial insemination in accordance with indications of infertility and assess expected results with regard to each successive insemination attempt.

There are major disparities in frequencies of successful MAP attempts among centres and laboratories, for reasons that are not only to do with differences in their patient groups. The ABM publishes standardised birth rates per MAP centre in the form of a graph that is by no means easy to read. For 2016, they went from 9.7% to 32% for IVF and from 6.2% to 16.8% for artificial insemination. The size of such differences suggests that fuller, more easily readable information should be provided to the public.

The CNAM is being too slow in adapting the nomenclature of biological procedures to technical changes in the current bioethical framework. This penalises IVF in particular, a major proportion of expenditures on which are to do with biological procedures (between 22% and 35% depending on centre status and technique used). Following opinions delivered by the High Authority for Health, updating of nomenclature of biological procedures should be completed as rapidly as possible.

Recommendations

36. Analyse the usefulness of artificial insemination in treatment of infertility, basing such analysis on patient data and information communicated by laboratories, in order to justify the number of attempts reimbursed by *Assurance Maladie* (Ministry responsible for health, and CNAM).

37. Improve the information provided to the public on results obtained by clinico-biological centres and artificial insemination laboratories in terms of births resulting from MAP and multiple birth rates (Agency for Biomedicine).

38. In compliance with the Court's reiterated recommendation that nomenclature of medical biological procedures be more frequently updated, set an imperative deadline for adapting such nomenclature for procedures reimbursable by *Assurance Maladie* following the recommendations delivered by the HAS (Ministry responsible for health).

10 Social security funds' service relationship with insured parties in the digital age: changes requiring expansion

A growing role for teleservices

General scheme social security funds provide teleservices in five fields: requests for benefits, simulations of rights, management of insured parties' files, monitoring of procedures undertaken, and messaging.

The development of teleservices has led to far-reaching changes in funds' relations with insured parties, enabling the latter to carry out a growing number of procedures online (on a computer or mobile phone) from a personal account, or on terminals located in physical reception areas.

All households that receive benefits paid out by Family Allowance Funds (*Caisses d'Allocation Familiale* – CAFs) have a personal account on the Internet. At end 2018, there were also almost 29.6 million *Ameli* (*Assurance Maladie*) personal accounts (as against 20 million at end 2015) as well as 8.5 million personal accounts for the old-age branch (as against 7 million at end 2017).

2018 saw a monthly average of 45.8 million connections for the family branch, 27.6 million for *Assurance Maladie* and 3.9 million for the old-age branch.

Unequal degrees of change

Although the teleservice offer is developing steadily, some administrative procedures are still not accessible online. Such is the case, for example, with requests for benefits and declarations of resources (disability pensions, minimum old-age pension or early childhood benefit supplement for childcare of the parents' choice for families requiring the services of a *crèche* or *micro-crèche*).

Despite the development of digital usages, traditional means of contact – telephone, letter and physical reception – may be on the decline but are still widely used by insured parties.

Digital technology undoubtedly simplifies procedures, facilitating automated allocation of benefits and reducing the obligations of declaration of data and production of documents incumbent upon insured parties. But such obligations are still burdensome and remote data transmission does not necessarily result in less time being taken to process their requests.

Social security funds' service relationship with insured parties in the digital age: changes requiring expansion

Social security funds have gained in productivity as a result of digital technology, largely due to remodelling of physical reception (replacement of counter reception by self-service areas, and reception by appointment) and a drop in numbers of telephone calls. However, in departments responsible for allocation of benefits, productivity gains are hampered by the complexity of the regulations concerned, incomplete functionalities of often outdated IT applications and continuing manual processing that needs automating.

Objectives and management agreements signed between general scheme social security branches and the State for 2018-2022 include stronger commitments on quality of service to insured parties. But there are still recurrent weaknesses in the service relationship. For example, levels of satisfaction regarding telephone calls (waiting times and response quality) and emails (slow responses) are inadequate. In the absence of appropriate responses, reiterations of contacts are frequent when they are measured at all. There are also inadequacies in the way complaints are managed.

Facilitating digital relations between insured parties and funds

Despite the "Share your information once" principle enshrined by the legislature in 2011, insured parties still have to declare information and produce documents already in the hands of other administrations (such as the notice of assessment for social security levies on disability pensions).

In order to rectify this, there needs to be better pooling of data between administrations. Increased pooling could take the form of new reconciliations of files between administrations and individualised exchanges of data in the context of FranceConnect[11]. Social security funds are still unequally involved in this latter system.

Another concern is the need to reduce the all too frequent errors that impact benefits paid out, due to erroneous declarative data and errors in its processing on the part of the funds concerned. The way in which benefits are calculated needs to evolve towards acquisition of reliable data and universalisation of its automated processing. With this in view, the monthly resources base introduced for the reform of housing aid[12] should also be used for the Active Solidarity Income (*Revenu de Solidarité Active* – RSA), the Employment Bonus (*Prime d'Activité* – PPA), disability pensions and Complementary Universal Health Insurance (*Couverture Maladie Universelle-Complémentaire* – CMU-C)

In contrast to practices that have so far tended to be followed, the scheduled remodelling of applications for management of benefits should

[11] Using a single username and password, insured parties can access their personal accounts in the various administrations concerned. They can also authorise them to share their personal data (such as income tax assessments).

[12] Largely supplied by data from employees' Nominative Social Declarations (DSNs) and social security benefits received.

systematically integrate deployment of teleservices and dematerialised provision of information to insured parties from the very outset (through enabling them to consult their files' situation or by sending emails).

Taking account of the needs of all insured parties

Around 18% of adults either never use or are not at ease using IT tools; the rate is 23% for 60-69 y/o and 46% for non-graduates.

Social security funds need to step up actions designed to reduce the "digital divide" in use of the services they provide to insured parties. To this end, the sickness and old-age branches should deploy a national digital inclusion strategy, as the family branch has already started to do.

Each of the general scheme's branches deploys its own teleservices. In order to simplify procedures and facilitate insured parties' access to their rights, inter-branch pathways need to be defined for the various major life events. For example, it should be possible to declare pregnancies on a teleservice common to the sickness and family branches.

Better coordinating means of contact in accordance with insured parties' situations

Social security funds have reduced numbers of physical reception sites, offices hosted by partners and receiving few insured parties in particular, as well as often reducing their opening hours. At the same time, service offers provided by partners have become more accessible, above all following the creation of Public Service Centres (*Maisons de Services au Public* – MSAPs) in 2015.

Taking account of the development of teleservices, social security funds have introduced graduated responses to insured parties' requests: an initial level of assistance with procedures and help with use of teleservices, provided by the funds or partners; and a second level of expert information on regulations in force, monitoring of individual files and personalised handling of complex situations, provided by funds.

The existence of local offers right across French soil should be ensured, mainly provided by partners, with accessibility to second-level offers ensured by the funds themselves.

As regards the first-level offer, the Government has decided to create 2,000 *Maisons France Services*, which will take over from MSAPs by 2022, with a reinforced "core" of common services.

The second-level offer's accessibility depends in particular on development of remote appointments (telephone or online appointments) and improvement of the quality of telephone responses.

Physical reception also needs improvement, in particular as regards appointments, in order to avoid people having to queue at counters when complex situations have to be dealt with. Reception on appointment is not always adequately targeted, prepared, or conclusive, which tends to result in repeated contacts.

Social security funds' service relationship with insured parties in the digital age: changes requiring expansion

Lastly, teleservices are partly juxtaposed with rather than substituted for traditional means of contact: data and events are declared several times on different supports, and benefits and allowances are requested several times using different methods. In addition, insured parties continue to turn up at physical reception facilities, send letters and make phone calls for procedures that could be carried out online.

In order to direct insured parties to the modes of contact best suited to their needs; funds should analyse such needs, define an offer adapted to complex or fragile situations, and determine which channels to prioritise; such modelling of user pathways has scarcely begun. Funds also need to possess information systems that enable them to retrieve all contacts from insured parties and the reasons for them; this is not yet the case in the family and old-age branches.

Recommendations

39. Simplify insured parties' procedures by universalising formalities that can be carried out on their personal spaces on caf.fr, ameli.fr and lassuranceretraite.fr websites; by providing teleservices common to branches for declaration of major life events (pregnancy, birth, separation, retirement or loss of a spouse); by developing teleservices using the FranceConnect system, via which insured parties can authorise collection and use of their personal data by the administrations at its origin (Ministries responsible for social security and the digital sector, and national funds).

40. Extend use of data from the monthly resources database to all entitlements and benefits whose calculation so requires, along with the sharing between administrations of information bearing on residence, life events and recognised entitlements (certificates), in order to reduce required formalities, errors in allocation and calculation of benefits, and non-take-up of social rights (Ministries responsible for social security, the budget and the interior, and national funds).

41. Set general scheme branches new or more ambitious goals with regard to quality of service to insured parties in five fields: accessibility of telephone reception services, quality of responses to telephone calls and emails, reduction of repeated contacts, development of remote appointments, and assistance with use of the social security system's digital tools (Ministry responsible for social security, and national funds).

42. Continue with adaptation of local location of funds in order to provide a graduated service offer, by developing individualised assistance physically accessible at fund premises or remotely by phone or online appointments, and by improving local reception partnerships (national funds).