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Sickness insurance and managed care

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Abstract[1]

Sickness insurance schemes anxious to keep up with or accelerate the process of innovation in health systems are moving towards the introduction of managed care models.

In our report, we pose a number of questions concerning this new organizational framework for care systems, based on greater rationalization of the health sector, and the use of procedures and methods which vary from country to country.

We will examine the options chosen by social security institutions. As administrators of the risk, they have a central role to play in the implementation of new organizational frameworks and their control, in the search for optimal management of the health sector. This policy is in line with the trend to give more responsibility to the actors involved in social security and with the modernization of the institutions.

We will illustrate our text with examples from several countries (France, Great Britain, United States, Switzerland and Chile). Based on this information, we will attempt to highlight the positive aspects, the difficulties and the problems encountered in the implementation of managed care.

The examples highlight the long-term strategic impact of a model which should favour the integration of medicine and certain public health sectors (prevention). This model contributes towards improving the general consistency and performance of the health system and providing better care for patients. However, in most of the countries which have adopted this new approach, opinions and interim assessments remain divided as regards its contribution to the development of better care and control of health expenditure.

The introduction of this model means many changes in the conditions under which health professionals work, the organizational conditions of the system for the distribution of care, and in the content of the health services and care reimbursed by the sickness insurance. The role of sickness insurance is reinforced by the need for performance evaluation. Furthermore, it retains its central role in the protection of the most vulnerable population groups (by providing information and protecting their private lives) in the face of a certain number of problems which have been encountered.
However, the examples provided by various experiments in managed care clearly point to this approach as one of the structural models to be used within a range of actions. There is no doubt that a pluralist approach, combined with greater transparency as

[1] This report has been written with the collaboration of Monique Vennin-Laird, responsible for Foreign Affairs, European and International Mission Relations and Cooperation of the National Sickness Insurance Fund for Employees.

regards the underlying values of each health insurance system, is one of the best safeguards of the social contract which is a basic component of all health systems.

Introduction

Social security institutions in countries throughout the world are currently faced with the need to adapt to changes in the health sector brought about by demographic, sociological, economic and technical evolution and development. This adaptation process reflects the need to respond more effectively to the needs of the population covered. This is in fact the subject chosen by the International Social Security Association (ISSA) for the Stockholm Initiative in 1998: "Social security reform: In search of a new consensus.

In most countries, the actors agree that traditional health systems need to move towards "global health care" to replace "the divisions between individual health measures and community health, between the social and economic aspects of health, between preventive and curative services, between specialists and general practitioners, between the public and private sectors, between providers and users of the health service".[2]

Within this framework, experiments have been carried out on new approaches to care management at the microeconomic level. In current reforms, the structure and management tools as well as the treatment provided are often based on theories drawn from managed care.

Our report will focus on this new framework for the organization of care systems based on greater rationalization of the health sector, using different procedures and methods depending on the countries.

Social security institutions are showing an interest in these new methods of organization which by definition aim at the control of health expenditure and the preservation of sickness insurance acquisitions (equity and solidarity) in order to provide access to high quality health care for the population as a whole.

We will use illustrations drawn from experiments carried out in several countries (France, Great Britain, United States, Switzerland and Chile) involving social security institutions. On the basis of the information thus obtained, we will try to show the positive aspects, the difficulties and the obstacles encountered in the implementation of managed care. In so doing, we will focus on sickness insurance,[3] as one of the main components of this global system which includes patients, health professionals and health institutions.

[2] World Health Organization (WHO) Europe, project "Towards Unity for Health", 2001.

[3] "Sickness insurance" includes the basic statutory schemes financed from members' contributions and/or taxation. The text published by K.G. Scherman (International Social Security Review, Vol. 53, No. 1, 2000) concerning the Stockholm Initiative indicates: "The terms social protection, social security, social insurance, and even social assistance and welfare are used differently in different contexts, regions and countries. In this report these terms are used in a general way, mainly referring

1. The stakes

A redefinition of the equilibrium of the care system is what is at stake in the current transformations for all the actors (social security, patients, health professionals, the State). Such redefinition means decentralization and a new project (combining medicine and public health), to provide the necessary care and services of optimal quality at the lowest cost, while ensuring equity.

What are the pre-requisites for its efficient introduction and development: a computerized system combining management and medicine with coding of actions, lists of medication, coordination of health professionals, further professional training to guarantee the quality and efficacy of medical performance, information of the patient, etc.?

Has managed care proved its worth as a management tool at the micro-economic level? Are the methods of control on which it is based compatible with the underlying values of social security activities?

What is the level of involvement of sickness insurance and its role in the implementation of managed care in terms of funding, legislation, and the implementation of field experiments? What are the levers which sickness insurance should preferably rely on, in its use of this regulatory tool? What are the strong points and the weaknesses which have come to light during the various experiments concerning its use?

2. The managed care framework

This management model was developed in North America, within the context of a competitive economic system and sickness insurance based on both public and private programmes. The theoretical principles of managed care have been relatively well documented, since it took off in the seventies. However, in practice there are as many different management formulae, both in the United States and in those countries with economic and political structures which are far removed from the original model.

The following definition is a wide one, based on the terminology used by the American Medical Association: "A managed care system is a group of systems and techniques used by any delivery service, administration or insurance in the health sector, which controls or influences: the accessibility, use, quality, cost and price of health services for a given population." This definition is very close to that of the American Public Health Association which describes it as: "Any system for the financing and/or distribution organized so as to

to public arrangements to support individuals in such circumstances and with such measures as come under the definition of social security of the International Labour Office (ILO)."

monitor the use of health services by its affiliates, to limit their cost and/or improve their quality."

This general definition includes the sub-systems for:

- financing care (sickness cover);
- structured distribution of care (health professionals, care structures) for a defined (target) population;
- care management (control of the quality of care and health services, of their use by patients and cost).

A managed care system depends on the nature of the health system of which it forms a part: there is no unique model. In countries where there is a compulsory health protection system and where the health sector is based on a non-competitive economic model, the model will reflect certain aspects of microeconomic management techniques rather than the general economy of the project.

The objective of this management model is to provide the best possible care for each person treated, in an efficient manner and at the lowest cost. It implies that each of the three main actors of the system (patient, health professional and source of finance) assume their responsibilities and that there are control mechanisms to monitor their decisions.

The system is managed by those providing the financial resources and those providing care, who must work together in order to ensure the economic efficacy of the care system.

Sickness insurance schemes which implement managed care systems emphasize the following characteristics of sickness risk management:

2.1. Relationships between patients/members

Patients have access only to registered health professionals and services; if they wish to retain their freedom of choice, they will be reimbursed at lower rates or not at all. Patients take an active part in their own global health care, from prevention to the proper application of prescriptions, including the acquisition of knowledge in the health and economic sectors. Patients thus develop an "organizational culture". They become full partners.

2.2. Relationships with professionals

Health professionals are selected on the basis of specifications; their practices must fall within the framework of prescribed profiles and activities (professional guidelines for the treatment of the most common pathologies are provided). As regards primary access, general

practitioners are responsible for filtering access to other levels of treatment (specialists and hospital care).

Under this system, medical decisions must be based on proof of efficacy (evidence-based medicine) and diagnosis and treatment must be cost-effective. Professional interventions are based on guidelines of good medical practice and medical references. Finally, priority is given to health promotion and sickness prevention activities.

In addition to reflecting best practice in the way they carry out their professional activities, health professionals must acquire new expertise: management skills and the management of medical and administrative data. They are responsible for the information contained in patients' medical files and the transmission of data concerning the management of their surgeries. This level of qualification and performance in the fields of both medicine and management calls for life-long training. Regular professional updating is a requirement for continued professional exercise. Finally, in so far as the health professionals are responsible for the quality of the care provided, their performance is assessed and the results are frequently disseminated among the other partners, including patients.

2.3. Control of health expenditure

There are many types of mechanism which can be used to restrict access to care and medical attention, such as: initial visit to a doctor (gatekeeper), for referral to specialists, hospital services and medical laboratories. Another alternative, in the case of "disease management", is for all the professionals involved to define the procedures and therefore the cost of care. Health professionals may receive an incentive payment for introducing economies.

Under this system, health professionals are obliged to assume responsibility for the cost and quality of treatment for the specific population group in their care. It means that they share the financial risks with the insurer. This is a long way from traditional relationships between health professionals and sickness insurance, where only the insurer has to face a deficit if the budget is overspent. For example, American doctors under contract to one body (Health Maintenance Organization (HMO)) usually accept "capitation" contracts (i.e. a pre-established global sum for each patient on their register for a given period of time) and they assume the financial risk if they exceed a pre-defined number of examinations and acts (radiology, laboratory, hospitalization and out-patient care, specialist consultations, prescription of medication and para-medication). The autonomy of the health professionals is reduced, as their level of responsibility increases.

2.4. The organization of treatment

Emphasis is placed on the coordination of treatment between professionals, and between out-patient and hospital services, in the interest of optimum utilization of the resources of the care system as a whole.

The role of sickness insurance is reinforced in this type of system, since it is in a position which enables it to demand performance evaluation, on the basis of regular information supplied by the health professionals.

3. Information from other countries

3.1. The United States: A system entirely based on managed care

The American model, as the original, offers a long-term perspective on its use in the context of a market economy where health care is seen as a marketable service of a non-specified kind. In recent years, the continued rise in the cost of treatment has led American employers to support the development of the option of managed care.

Within this system, health professionals underwrite fixed-term contracts with insurers within the framework of a managed care plan. In this way they become part of structured organizations: networks (managed care organizations), of which the most striking example is that of the HMO.[4] Doctors sign exclusive contracts with the insurers (HMO group model) or are taken on as employees (HMO staff model).

Patients go for treatment to registered health professionals listed in their sickness insurance policies: in the case of HMO type networks, they are obliged to consult health professionals who belong to the network in which case they are reimbursed without having to lay out any of the costs; otherwise, those included Preferred Provider Organization (PPO) networks. Other options are available: the Point of Service (POS), where patients are free to consult a doctor of their choice (outside the network) and designate one of them as responsible for the coordination of treatment (contributions are higher and the reimbursements are lower). Finally, certain sickness insurance systems propose a free choice of professionals and reimbursement based on treatment (Fee for Service (FFS)).

[4] The HMO is an organization which incorporates the actors of the care network within the framework of one organization led by a paying client (the insurers are care producers and control the entire chain). There are several types of sickness cover:

- Group sickness insurance provided by companies for their employees with one or several insurance companies, based on capitation (sometimes adjusted for age and gender, but not based on medical antecedents). The employer covers approximately 75 per cent of the premium and the employee covers the rest.
- Individual sickness insurance policies proposed by the HMO or by traditional insurers.
- High risk pool insurance schemes created by certain States to cover those who are unable to obtain individual insurance on the open market.

The benefits and health services provided under these managed care systems are clearly defined by the insurer, for each level of health care (from primary to tertiary). This guarantees more efficient benefits from the point of view of both the insured and health professionals.

The following figure among the most important tools of managed care:

- Disease management based on medical prescriptions: the health professionals identify individuals at risk, treat them on the basis of medical protocols and follow their health evolution.
- Case management: the patient is treated within a structure of available care and receives the most suitable treatment at the lowest cost.
- Utilization review, based on the systematic analysis of treatment and benefits provided: this is based on a wide range of programmes and protocols which are intended to ensure that all the services and treatment received by the patients are based on their medical needs and supplied at the lowest cost, depending on the individual case. It is a way of training professionals which creates more homogeneity in the treatment of patients among professionals and their counterparts within the health system.

All of these tools rely on efficient systems for the processing of medical and administrative data. Managed care means a complex organization which has necessitated the introduction of a computerized Management Information System (MIS) for the publication of data and regular reports on various aspects of the programmes.

These tools can be seen as an innovation in the health system, which have helped to reduce waste in two areas: requests for superfluous treatment and inefficiency as a result of poor allocation of resources. Improvements have been noted in several areas: a reduction in hospital admission rates, in the length of hospitalization, the use of less costly procedures, increasing use of preventive measures and more general savings in the cost of treatment.

However, many issues continue to pose problems, particularly access to care and equity: too much emphasis on a market economy in the health sector means that priority is given to controlling costs and profit-making.

On the one hand, sickness insurance companies working in a competitive environment have become involved in fusions, acquisitions and borrowing, and on the other hand pressure from employers has encouraged competition between managed care insurance policies and traditional sickness insurance policies. Those insured practise a form of auto-selection in favour of less cover, at cheaper rates. The "good risks" or low-cost patients tend to migrate towards managed care contracts, which has led to the disappearance of traditional types of sickness insurance cover.
Different problems have arisen in the government sickness insurance sector (Medicaid), which is part of the managed care system. Apart from the need for more professional

qualifications on the part of its administrators (for the negotiation of contracts, construction of networks of care providers, recruitment of members, development of new methods of payment) efforts to control expenditure in connection with Medicaid centres have led to non-involvement on the part of health professionals in the treatment of low-income patients (the financial incentives were considered too low, as was the level of capitation).

As a last resort "safety nets" have had to be introduced for high risk and vulnerable population groups (pregnant women, mothers, new-born babies, children and old people) which were not covered by sickness insurance, in the form of sickness insurance provided by individual States.

Constraints have appeared which affect on the most vulnerable patients and have led to modifications in behaviour when seeking treatment (delay in calling upon health professionals); in addition to constraints affecting health professionals: the allocation of resources combined with financial incentives leads to conflicts of interest in the field of medical ethics (reduced reimbursement of treatment leading to shorter periods of hospitalization): a loss of autonomy in the exercise of their functions, because of strict monitoring and extremely stringent administrative controls.

3.2. France: From partnership coordination to contractual relationships

The various actors involved in the system noted that a lack of cover in certain sectors because of compartmentalization within the health system, particularly with regard to chronic diseases, dependence and preventive medicine; this led first of all to the development of informal health networks in the eighties, then to more formal "town hospital" networks in the early nineties. The legislators were then called in to recognize these new forms of treatment structure and to provide them with a legal framework. "This recognition constituted an important step in the search for a more rational approach in the French health system (…) the new approaches developed a structure based on demand (…) they focused on the pathology, and proposed a combination of various types of treatment."

In 1996, legislation was introduced which distinguished between two types of out-patient treatment: experimental treatment networks and systems (known as "Soubie networks"), which frequently applied waivers to the usual rules for the treatment of beneficiaries and the remuneration of independent health professionals and, in the hospital sector, registered networks approved by the Directors of the Regional Hospital Centres. In 2002, the law concerning "patients' rights and the quality of the health system" introduced a single term of definition, that of "health networks"; it also imposed quality criteria for networks financed from on public funds. Quality criteria were defined by the National Agency for Health Registration and Assessment (*Agence nationale d'accréditation et d'évaluation en santé* (ANAES)).

The Social Security Finance Act (2002) replaced the existing experimental approach with the generalized introduction of networks. Global financing was introduced at the same time to ensure their long-term survival; the modest amount involved in 2002 (23 million Euros) will rise to over 100 million Euros for 2004.

Sickness insurance has regularly supported measures in favour of the coordination of the activities of health professionals, continuity of care and the complementarity of care on offer, considering care networks and health networks in general[5] as one of the essential tools of this approach.

The different sickness insurance schemes have backed many experimental projects (more than fifty) particularly since 2000. The Agricultural Mutual Benefit Society, for example, has introduced a gerontological network to enable dependent old people to remain in their own homes. This network, based on 19 regional centres, has allied complementary town and hospital facilities by opening hospitals to general practitioners and coordinating the activities of all those who form part of the network in both the health and social sectors.[6]

The evaluation issue remains a major preoccupation for the regional actors (Regional Unions of Sickness Insurance Funds (*Unions régionales des caisses d'assurance maladie* (URCAM) and the Regional Hospital Centres (*Agences régionales de l'hospitalisation* (ARH)) as well as for the national actors (sickness insurance and the Ministry) which are all affected by the network development policy.

In 2001, a report published by the ANAES concerning the evaluation of the networks underlined the difficulties involved in long-term coordination between the network promoters and the institutional participants.

The URCAM survey underlined areas in which progress needed to be made. However, all the partners considered this approach to be a positive development and inescapable. Proposals were made to improve and develop coordination in order to make the networks more dynamic: to offer logistical help to promoters and to devise long-term modes of functioning; to create a tool to provide information and guidance on the treatment system for professionals and beneficiaries (in order to involve the user in the care system).

A certain number of the tools involved in managed care have been given priority by the sickness insurance. This included consultations with a "referral doctor" (gatekeeper),

[5] "A health network is an organized form of collective action provided by professionals in response to a health need on the part of individuals and/or the population, at a given moment of time, on a given territory. The network cuts across the existing institutions and measures. The notion of 'health network' includes that of care network", ANAES, *Mission evaluation réseaux de soins*, October 2001.

[6] Central Fund of Social Agricultural Mutual Benefit Societies, Health Department: Activities report "*organisation d'un réseau gérontologique*" (2002) and evaluation report (July 2003).

responsible for directing patients towards other providers of treatment; this option enables a registered general practitioner to take certain measures in exchange for a flat-rate annual global fee per patient.

A patient who chooses a general practitioner, whom he agrees to consult before going elsewhere, does not have to pay for his treatment in advance and benefits from agreed rates. The medical and economic efficiency of this depends on the "loyalty" of the patient. In addition, this loyalty and the need for follow-up encourages the health professional to invest in an efficient computer system based on modern information and communication technologies.

Other managed care tools have been implemented by the sickness insurance with the agreement of the health professionals: these include guidelines on medical practices which are recognized as scientifically and economically the most effective and least costly, the comparative medical references (*référence médicales opposables* (RMO)) (1993 Act). They must be included each year in an annex to the medical convention. There were 243 such medical references in 1998; 77 of them directly concerned medical prescriptions and covered 48 per cent of the sales value of reimbursed medication.

Since 1996, professional references on medication have been drawn up by the French Agency for the Security of Health Products (*Agence française de sécurité sanitaire des produits de santé* (AFSSAPS)), based on assessments which must be carried out to obtain marketing authorization and to assess a product's value in terms of the medical service rendered.[7] Recommended best practice guidelines currently exist in ten sectors.[8]

More recently, the agreements on good use of treatment (*Accords de bon usage des soins* (AcBus)) have been issued to encourage the collective evolution of medical practice. For instance, sickness insurance schemes realized that certain home calls were not medically justified, and came to an agreement with registered practitioners to encourage treatment at their surgeries. The agreement allows for increased fees for a medical act only when the state of dependence of a patient meets certain medical or social criteria. The objective, for the first year, is to obtain a national reduction of 5 per cent in the number of medical acts performed outside a surgery. Faced with enormous regional differences, those partners to the agreement have made allowance for regional differences by making the regions responsible for defining medically valid criteria for home visits.

[7] The Act concerning the "medical control of care expenditure" (1996), the constitution of the *Agence nationale d'accréditation et d'évaluation en santé* (ANAES) and the transformation of the *Agence du médicament* into the *Agence française de sécurité sanitaire des produits de santé* (AFSSAPS), as well as agreements between sickness insurance schemes and health professionals (1999) have brought about important changes in the nature, field and methods of updating of the RMO as well as in the production of new references of good practice.

[8] Available on the Web site of the *Agence française de sécurité sanitaire des produits de santé* (*www.agmed.sante.gouv.fr*).

Over and above improvements in the organization of care, coordination between the actors also depends on the implementation of various communication tools: the introduction of a medical file on each patient (check-ups, treatment schedules, etc.), computer systems designed for following up professional practices (protected information as regards the patient), compatibility between the computer systems of the care networks, a medical liaison and communication document between the doctor and the patient.[9]

The place and role of sickness insurance in the development of managed care have become clearer. The insurance sector has undertaken to continue its action in favour of the development of new convention-based relations with self-employed professionals.

In defining the reciprocal rights and obligations of health professionals and of the funds, the conventions do indeed adopt the approach of medical optimization of care: a common desire to participate in improvements in the performance of the care system and its effective utilization by patients (2003 Convention).

3.3. Great Britain: The evaluation of professional practices of general practitioners

The first reform of the National Health Service (NHS) in the nineties, introduced the tools of managed care by making a distinction between care users, such as the purchasing groups created by general practitioners (General Practitioner Fundholders) and care providers, the hospitals.

However, problems connected with this system of "domestic markets" led to a drop in the quality of care, as a result of pressure on the patient and on health professionals. This in turn led to the introduction of another model.

Currently, the responsibility for care purchase lies with decentralized structures, the Primary Care Trusts, within the National Health System. Their role is to purchase hospital care, organize primary health care based on contracts with all the general practitioners in each region and coordinate medical and social care for the population.[10]

Originality lies in the fact that the contract for implementation is between the NHS and the medical surgery. It includes indications on monitoring the quality of the care provided and its proper remuneration. This auto regulation exists in the context of a group medical practice. The latter relies on a strong tradition of assessment of the quality of treatment, control of the

[9] National Medical Convention, sickness insurance (January 2003): The medical liaison document is the property of the patient, who chooses the medical practitioner responsible for keeping it up to date (introduced in 2004).
[10] Chevrier-Fatome, C. 2002. Ministry of Social Affairs, France: Report No. 105 of the General Inspectorate of Social Affairs.

cost of prescriptions for medication and "cross-controls" between doctors treating out-patients and hospital doctors.

The most important innovation of this new reform lies in the reinforcement of the quality of the care dispensed through the introduction of regular and systematic assessment of the practices of health professionals, the five-year renewals being based on annual assessments.

The assessment criteria which define "Good Medical Practice" are laid down by the professional association of medical practitioners. Each year the result of the individual assessment enables a plan to be drawn up to assist individual doctors (through further education) to improve their professional skills.

3.4. Switzerland: Responsibility lies with the patient

In Switzerland, managed care models were introduced via universal sickness insurance legislation (*Loi fédérale sur l'assurance maladie universelle* (LAMal), 1995); one of them restricted the choice of care providers; the other, less restrictive, provided franchising and bonus systems for "economy-minded" patients. Plurality of insurance models remains a keynote. The health authorities considered that the sickness insurance and organizations providing care were well-placed to make patients more aware of their responsibilities (and consequently bring about a reduction in health expenditure).

Various measures have been designed to induce a greater sense of responsibility on the part of the insured by increasing their awareness of health expenditure. The following figure among the incentives introduced: insurers accept higher franchises in return for lower contributions; insured persons who do not apply for reimbursement in the course of a year, acquire a bonus (calculated over a five-year period); sickness insurance contribution rates are reduced if the person concerned agrees to consult a medical "supervisor" (gatekeeper).

The introduction of a programme of second medical opinions is also aimed at influencing the behaviour of patients: contribution rates are reduced in they agree to request a second medical opinion before undertaking "elective" surgery.

In addition to providing financial incentives, the care networks have made major efforts to provide information and training on prevention. Certain care networks have introduced advisory committees composed of patients to define this "training opportunity for patients", in order to increase their involvement.

3.5. Chile: A new approach towards solidarity and equity

The various reforms in health and social protection introduced in Chile have had a major impact on countries in Latin America, in that they have put a wide range of innovations to the test.

Radical reforms were begun in the eighties, which introduced the private sector and decentralization, in a very short space of time.

The insured were asked to choose between 35 private sickness insurance bodies (*Isapres*) and the public system (*Fondo Nacional de Salud*).

Since 1990, an evaluation of the impact of the reforms has revealed the need to reorientate the private sickness insurance schemes and provide them with stronger supervision, in order to restrict risk selection and promote greater equity.

Measures primarily concerned: the elimination of periods without cover for certain risks, the restriction of selection of certain risks connected with alcohol consumption, etc., the introduction of the right of beneficiaries to withdraw from private insurance schemes (in the event of increased premiums and costly diseases).

In its experiments, the sickness insurance system in Chile, like many other sickness insurance systems, gave priority to financial issues as the prime mover in its reforms. The results of its experience draw attention to the guiding principles which underlie the public and private sectors: public sickness insurance safeguards the concept of health as a basic human right. Private insurance, however, sees health as a range of risks, and insurance as a profit-making economic activity.

"Few are the signs which indicate that national economies with a hybrid system (comprising public and private schemes) have been able to control costs while at the same time improving cover, health status, productivity, client satisfaction and equality."[11]

Discussion

Sickness insurance schemes which wish to accompany and reinforce innovations in health system, are moving towards the use of managed care models.

Experiments which have been carried out highlight the long-term strategic impact of a model designed to support the integration of medicine and certain public health sectors

[11] Dror, D.M. 2000. "Reforming health insurance: A question of principles?", International Social Security Review, Vol. 53, No. 2, International Social Security Association.

(prevention). This model contributes towards improvements in the global coherence and performance of the health system which lead to better treatment for patients.

However, in countries which have adopted this approach, opinions and interim evaluations remain divided as regards the support it provides to improve the quality of health care and control health expenditure.

The introduction of this model means a number of major changes and has implications as regards the conditions under which health professionals carry out their tasks, the organizational structure of the system for the distribution of health care, and the content of the material benefits and health services reimbursed by sickness insurance and those covered by the State.

This is obviously a move in the direction of modernization of the health sector: in addition to decompartmentalizing the interactions of health professionals both amongst themselves and with the health care services, it also implies breaking down institutional and administrative barriers.

The role of health insurance is reinforced by the need for performance evaluation. In addition, it retains its central role in the protection of the most vulnerable populations (their information and protection of private life) in the face of the difficulties which have been noted.

Certain countries including France, faced with the perceptive of increased participation of private insurance brokers in controlling the treatment on offer, have introduced legislation on the rights of patients as a response to concern about the responsibility of brokers and the confidentiality of information.

These examples of a variety of experiments in managed care clearly indicate that this approach has a role to play among the structural models which can be used within a range of activities. A pluralist approach, combined with transparency concerning the values which underlie each sickness insurance system, without a doubt constitutes a guarantee for the safety of the social contract which is always present in health systems.

References

International

Bocognano, A.; Couffinhal, A.; Grignon, M.; Mahieu, R.; Polton, D. 1998. *Mise en concurrence des assurances dans le domaine de la santé: théorie et bilan des expériences étrangères*, Centre de recherche en économie de la santé/Institut national de la statistique et des études économiques (CREDES-INSEE), November.

Bryant J.H. et al. 1997. "Ethics, equity and renewal of WHO's health-for-all strategy", *World Health Forum*, Vol. 18, No. 2, World Health Organization.

ISSA. *International Social Security Review* (especially the series from 1998 to 2003), International Social Security Association.

—. *The Future of Social Security. The Stockholm Conference, 29 June-1 July 1998*, Federation of Social Insurance Offices (ed.).

Observatoire européen des systèmes de santé (*http://www.euro.who.int/observatory*).

Scheil-Adlung, X. 1998. "Steering the healthcare ship: Effects of market incentives to control costs in selected OECD countries", *International Social Security Review*, Vol. 51, No. 1, pp. 103-136.

Simonet, D. 2003. "Managed care and traditional insurance: Comparing quality of care", *International Social Security Review*, Vol. 56, No. 1, pp. 95-113.

Chili

Infante, A. 1997. "Health information systems – making them work", *World Health Forum*, Vol. 18, No. 2, World Health Organization.

Jack, W. 2000. "Health Insurance Reform in four Latin American Countries", *Policy research working paper*, No. 2492, World Bank.

Kifmann, M. 1998. "Private health insurance in Chile: Basic or complementary insurance for outpatient services?", *International Social Security Review*, Vol. 51, No. 1, pp. 137-152.

France

Act dated 4 March 2002 concerning "patients' rights and the quality of the health system", art. 84: "health networks".

ANAES. 1999. *Principes d'évaluation des réseaux de santé*, Agence nationale d'accréditation et d'évaluation en santé.

Art. L162-31-1 of the social security code.

Bocognano, A. et al. 1999. "Concurrence entre assureurs, prestataires et monopole naturel", *Economie et Statistique*, No. 328.

Bourgueil, Y. et al. 2001. "Evaluation des réseaux de soins – enjeux et recommandations", *Rapport no 1343*, CREDES et Groupe Image de l'Ecole nationale de la santé publique (ENSP).

Central Fund of Social Agricultural Mutual Benefit Societies. Health Administration. 2002. Activities Report, experimental sector, organization of a gerontological network, July.

CNAMTS. Inter-scheme circular 30.12.2002: "Réseaux de santé", National Sickness Insurance Fund for Employees.

Dorfiac-Laporte, C. 2003. "Le réseau de soins", *Regards*, No. 23, National Centre of Higher Social Security Studies.

FAQSV and CNAMTS. 2002. Le financement des actions de coordination des soins de ville: rapport d'activité, Fonds d'aide à la qualité des soins de ville and National Sickness Insurance Fund for Employees.

Gadreau, M. 2002. Lettre du Collège des économistes de la santé, septembre 2001. Rapport d'activité du Fonds d'aide à la qualité des soins de ville, National Sickness Insurance Fund for Employees.

Grignon, M. 2001. *Quel impact du mode de régulation sur la performance en assurance maladie?*, CREDES.

Hospital networks registered by ARH directors: art. L6121-5 of the public health code.

Le Pen, C. 1998. "Gérer le risque maladie", *Les cahiers de l'assurance*.

Majnoni d'Intignano, B. 2001. *Economie de la santé*, Presses universitaires de France.

Mills, C. 1998. *Regards*, no 15, National Centre of Higher Social Security Studies, November.

Ministry of Employment and Solidarity. 2000. *Quel système de santé à l'horizon 2020?,* cf. chapter "La protection sociale", DATAR-CREDES, edited by La Documentation française, October, pp. 60-70.

de Pourvouville, G. 2001. "Réseaux et filières: approche économique et application au système de soins", Seminar Institut d'études politiques, Paris.

Sandier, S. 1999. "Le managed care et l'argent", *Filières et Réseaux*, No. 29-30, August-September.

Social Security Finance Act for 2002 (art. 36).

Statutes dated 24 April 1996. "Les réseaux et filières de soins expérimentaux".

Viñas, J. M. 1998. "Réseaux de santé et gestion du risque", *Actualité et dossier en santé publique* (ADSP), No. 24, September.

Switzerland

CNAMTS. 2000-2002. International research mission series of reports on the Swiss health system, National Sickness Insurance Fund for Employees.

Cristofari, J.J. 1998. "Suisse: les modèles alternatifs coûtent moins cher", *Filières et réseaux*.

Dumont, J.P. 1999. "Les réseaux de soins coordonnés en Suisse", *Note et documents no 12*, Unions régionales des caisses d'assurance maladie (URCAM) de Bourgogne.

United States

American Association of Public Health (*http://www.apha.org*).

American Medical Association (*http://www.ama.org*).

Chaperon, J. et al. 2000. "Les 'Primary Care Physicians' Américains", *Journal d'économie médicale*, October.

Lavollay, M. 1998. "L'assurance maladie aux Etats-Unis", *Regards*, No. 15, National Centre of Higher Social Security Studies, November.

Nash, D.B. et al. 2001. Connecting with the new health care consumer: defining your strategy, Aspen Publishers, United States.

Wait, S. 1997. "Le glossaire du managed care", *Filières et réseaux*.