1st EURO HEALTH FORUM

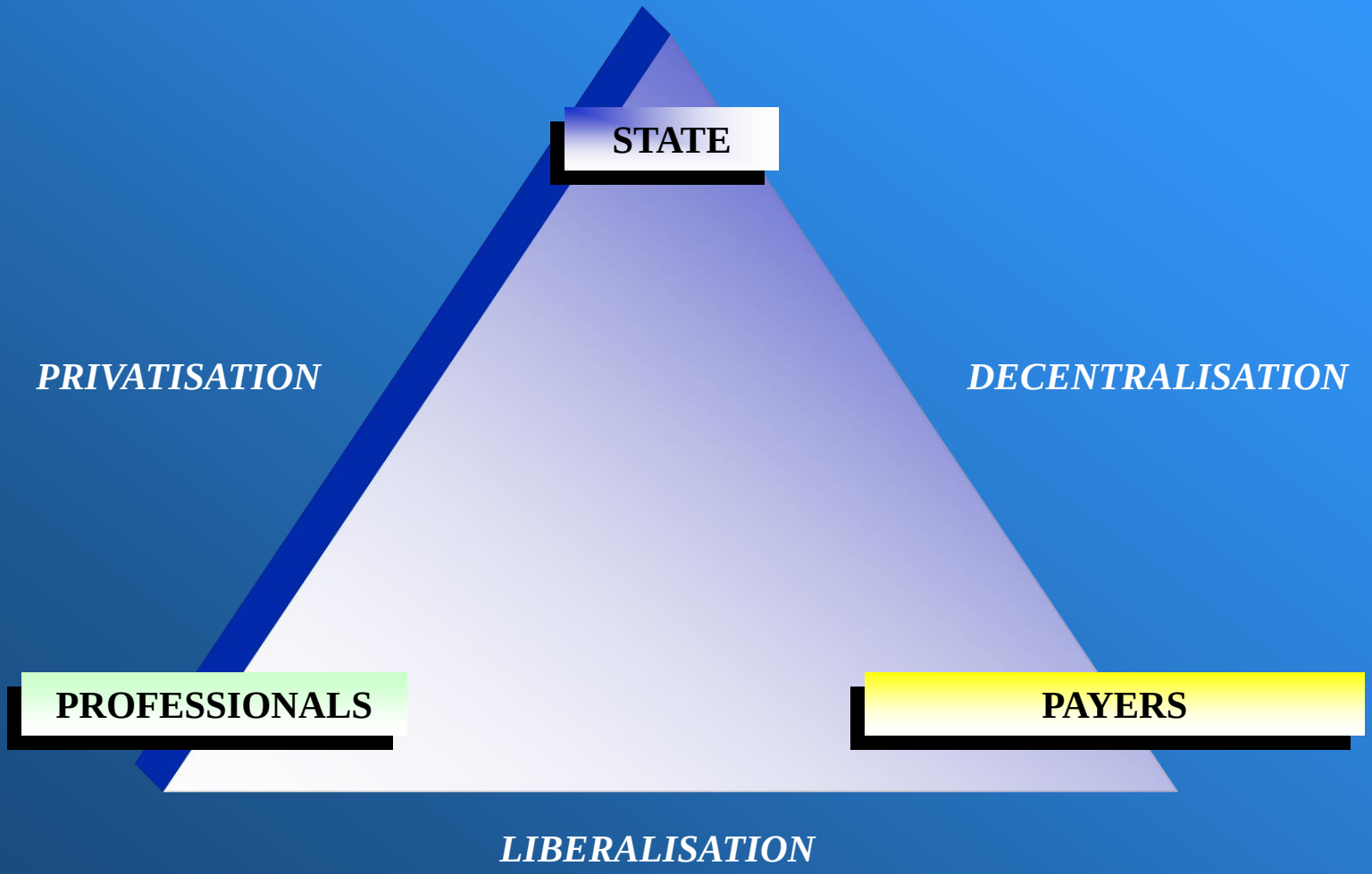
27 October 2004, Paris

Does the Europe of 15 have models to offer and do the 10 new members have solutions to share?

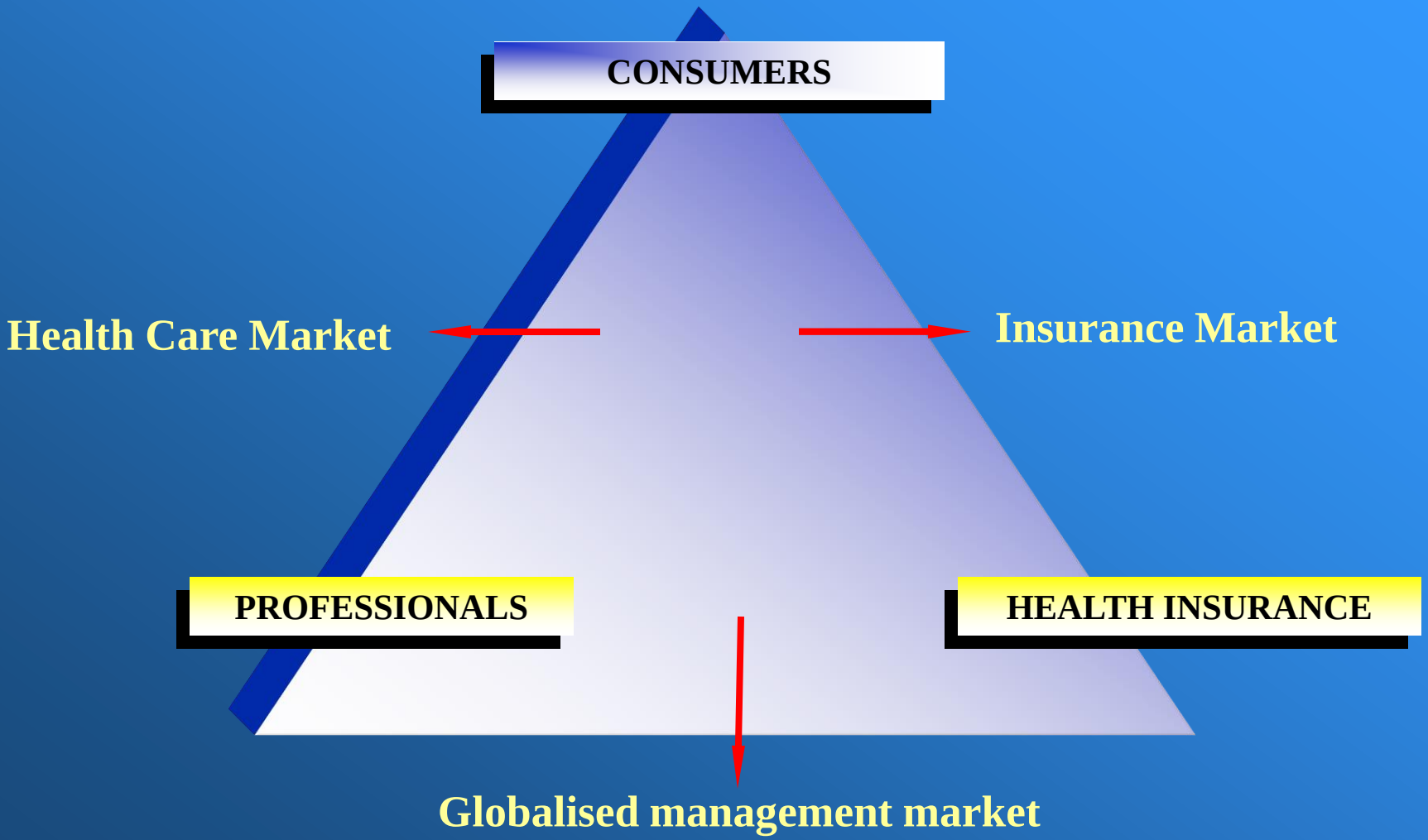
Prof. Robert LAUNOIS

(Université Paris XIII)

Basic Principles



Three Markets



Competition by Price: « Back to Europe, Back to Bismark »

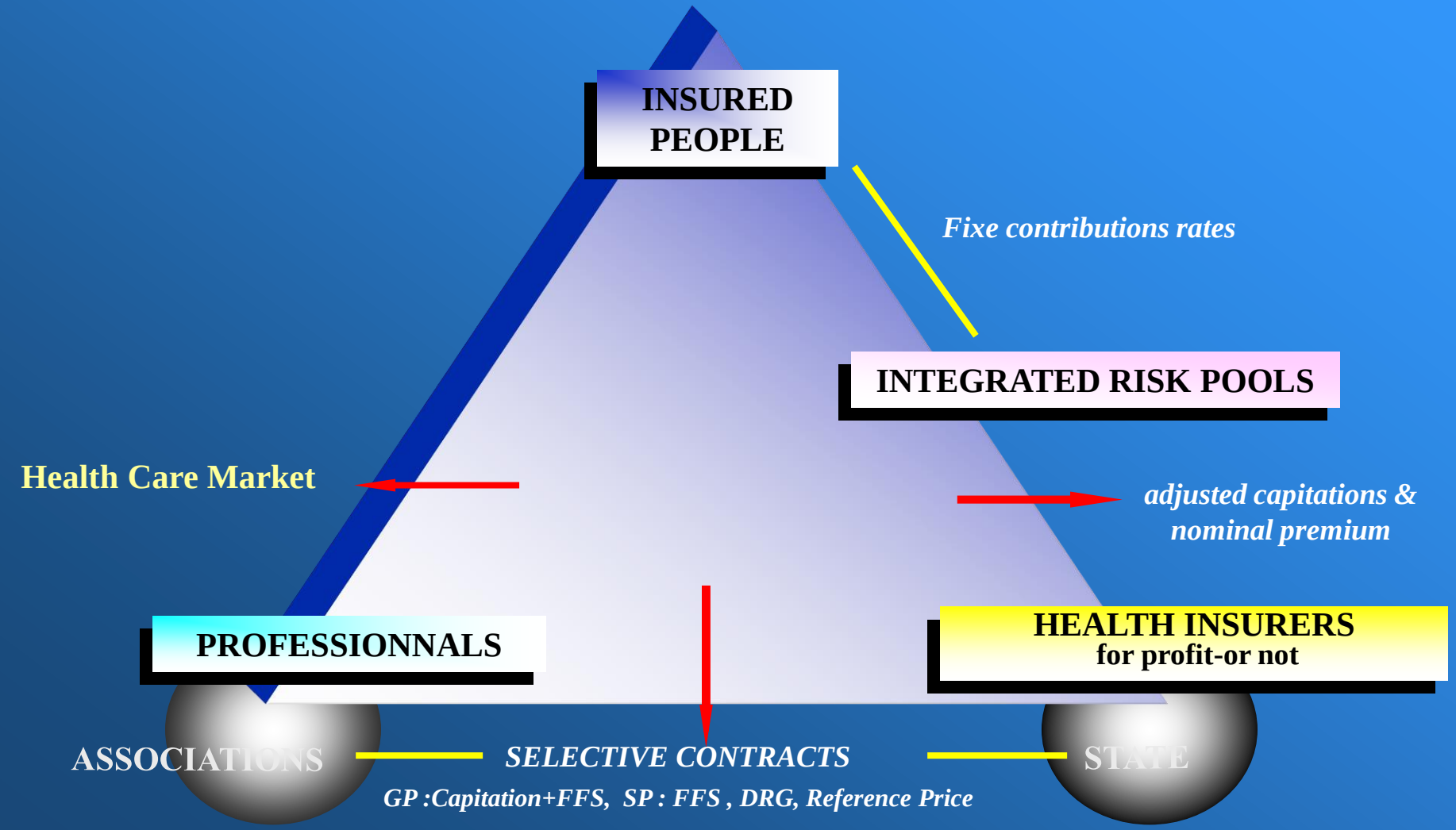
Health Insurance Systems of the New Entrants

COUNTRY	DATE OF FORMATION	NAME	ORGANISATION ATTACHED TO	STRUCTURE	CHARACTERISTICS
ESTONIA	1992-1994	Central Sickness Fund (CSF)	Independent public institution	- 1 national fund *(17 regional funds)*	1 single purchaser
HUNGARY	1991	Health Insurance Fund Administration (HIFA)	Ministry of Finance	- 1 national fund	1 single purchaser
LETTONIA	1995	State Compulsory Health Insurance Agency (SCHIA)	Ministry of Social Affairs	- 1 national fund *(8 regional funds)*	1 single purchaser
LITHUANIA	1997	State Sickness Fund (SSF)	Prime Minister	- 1 national fund	1 single purchaser
POLAND	1999	National Health Fund (NFZ)	Ministry of Health		1 single purchaser
CZECH REPUBLIC	1992	General Health Insurance Fund (GHIF)	Tripartite administration	- 1 national fund - 7 special fund systems	Multiple purchasers in competition
SLOVAKIA	1994	General Health Insurance Company (GHIC)	Tripartite administration	5 health insurance funds GHIC+CHIC+3 special fund systems	Multiple purchasers in competition
SLOVENIA	1945-1992	Health Insurance Institute of Slovenia (HIIS)	Paritarisme + ONDAM voted by parliament		1 single purchaser

HiT European observatory on Health Care Systems – WHO Regional Office for Europe

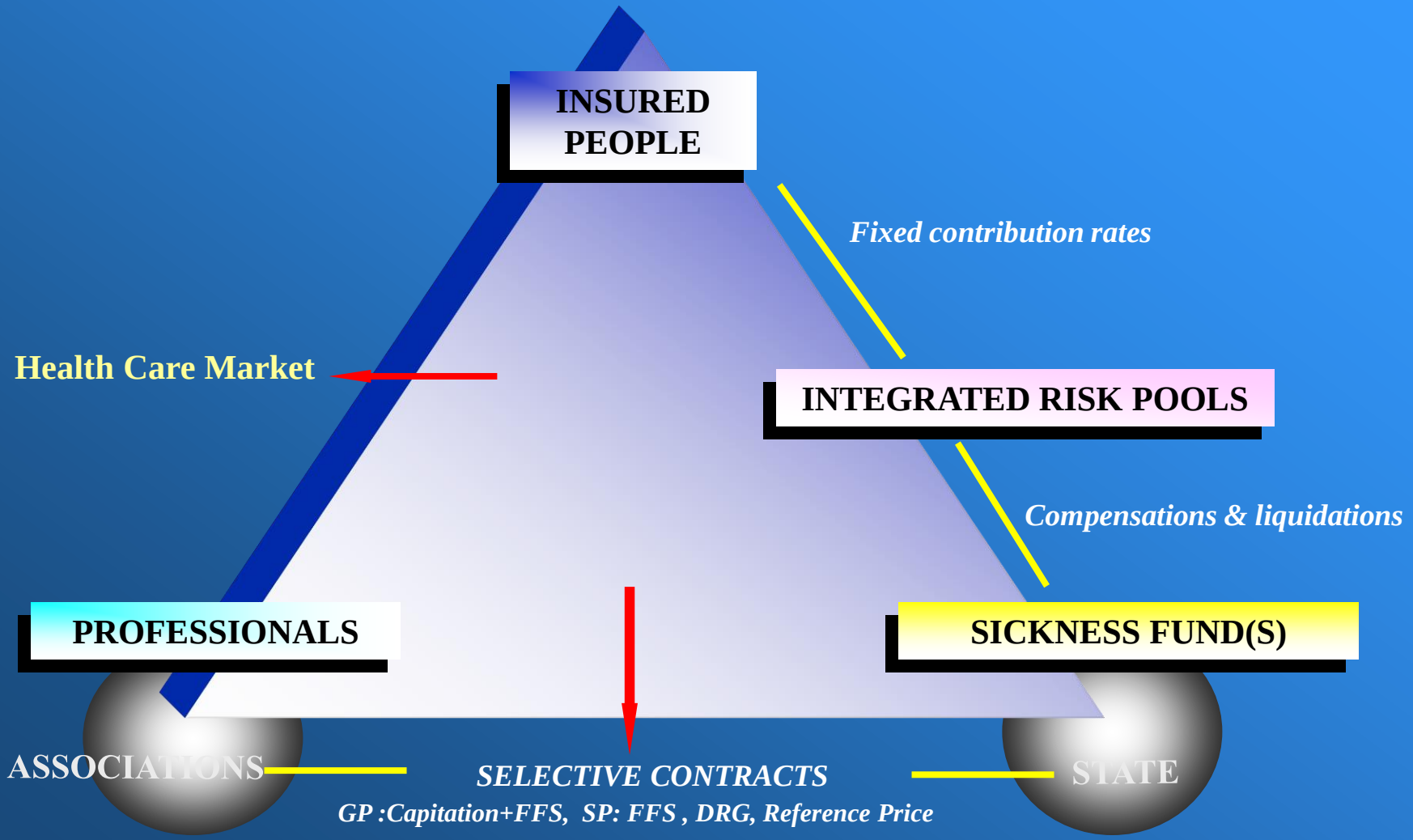
Compulsory Health Insurance With Free Choice of Health Insurers

** Germany (1996), Netherlands (2003), Czech Republic(1997) , Slovakia (2004)*



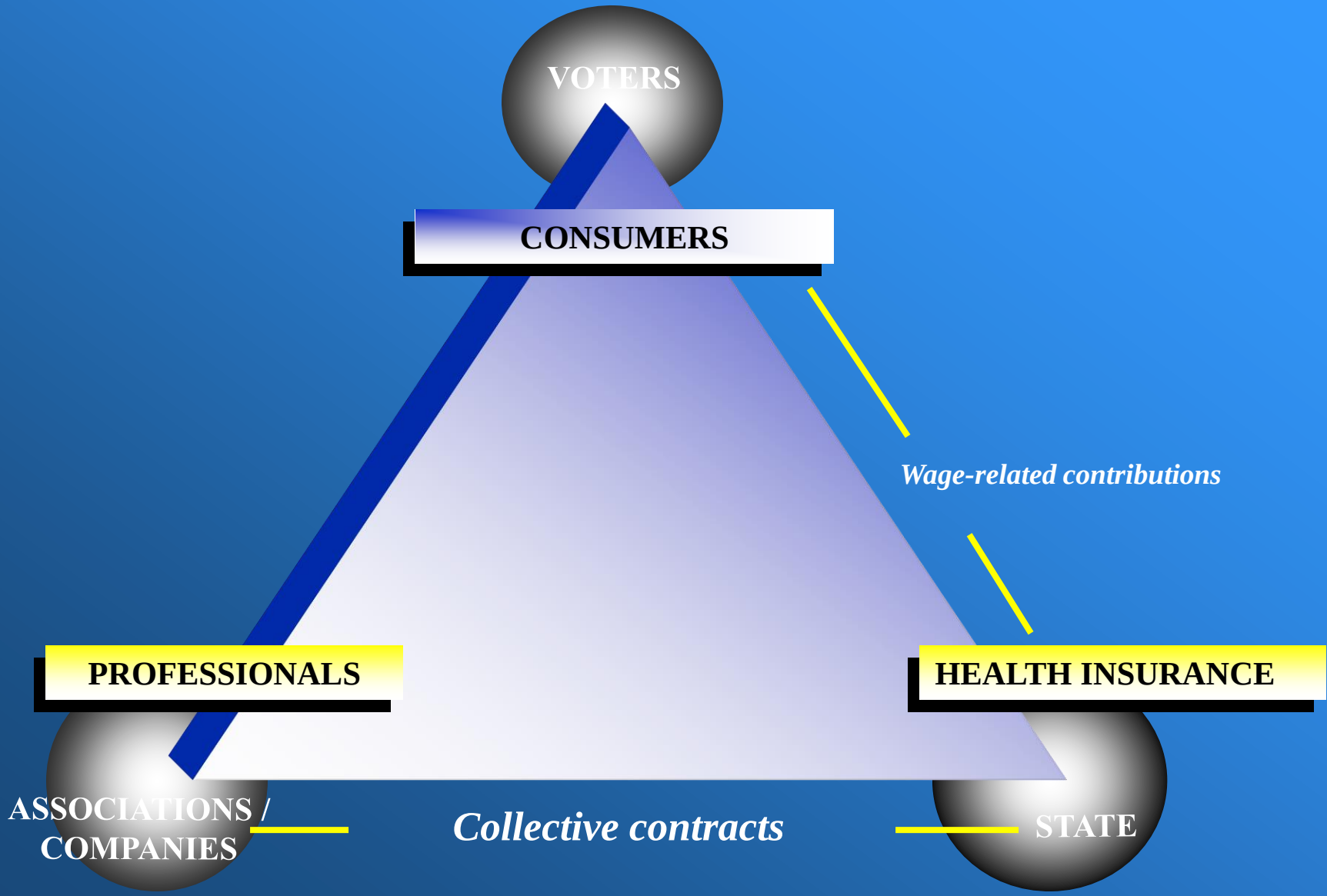
Compulsory Health Insurance Without Free Choice of Health Insurers

** France, Estonia, Hungary, Lettonia, Lithuania, Poland, Slovenia*



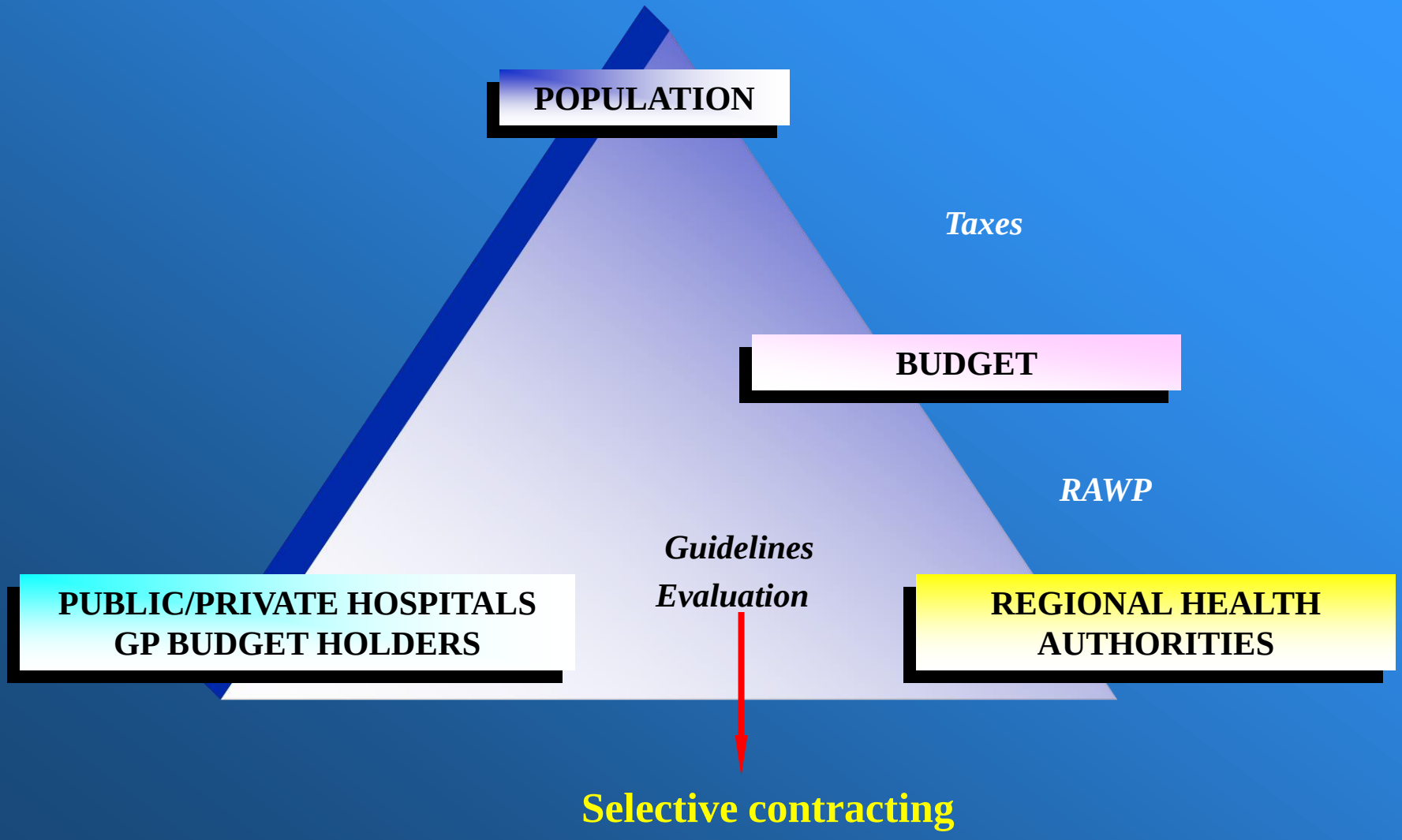
Competition by Quality
« Clinical Governance »

Professional and Democratic Logic



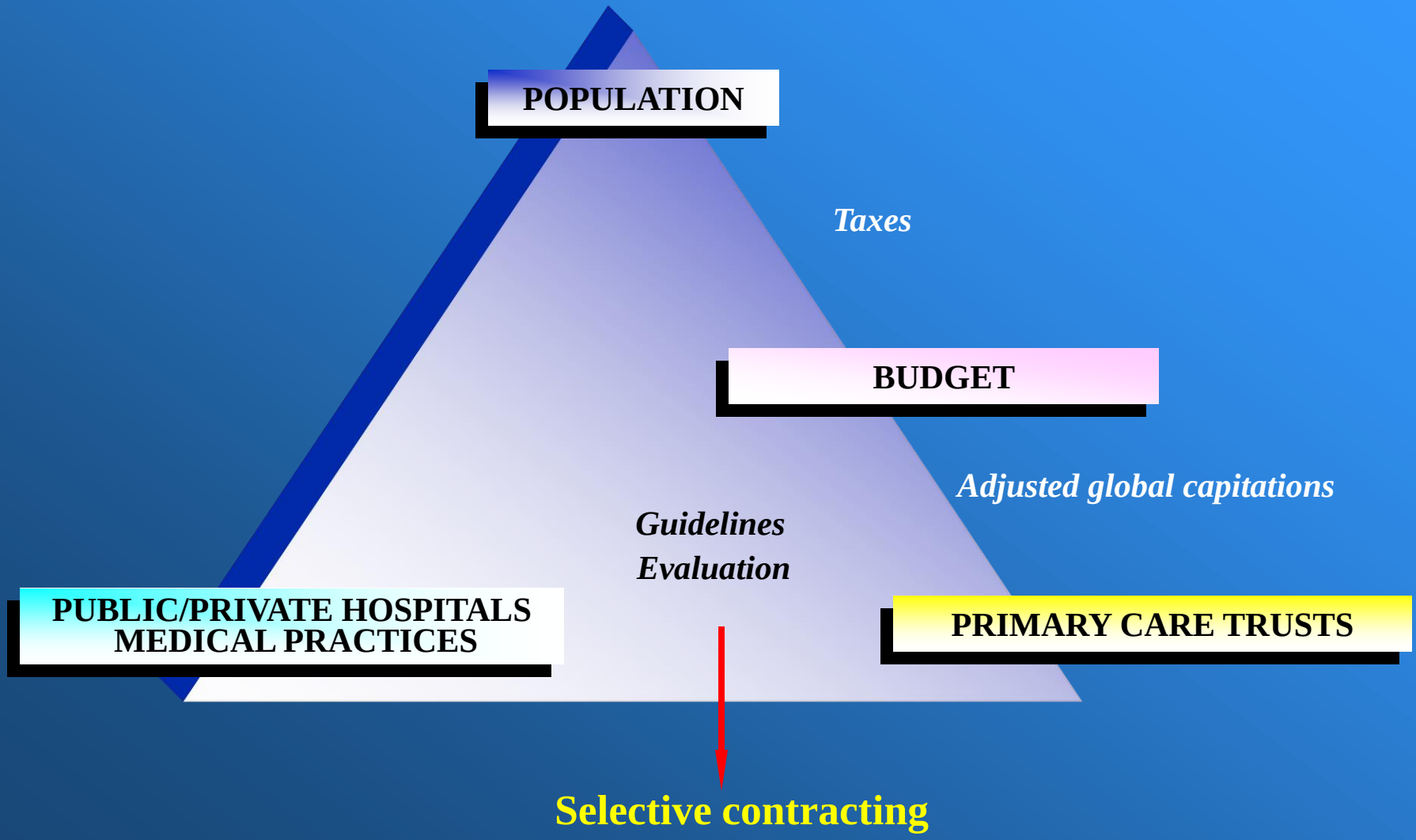
National Health System and Deconcentration

** England 1991, Scandanavian Countries, Lettonia (?)*



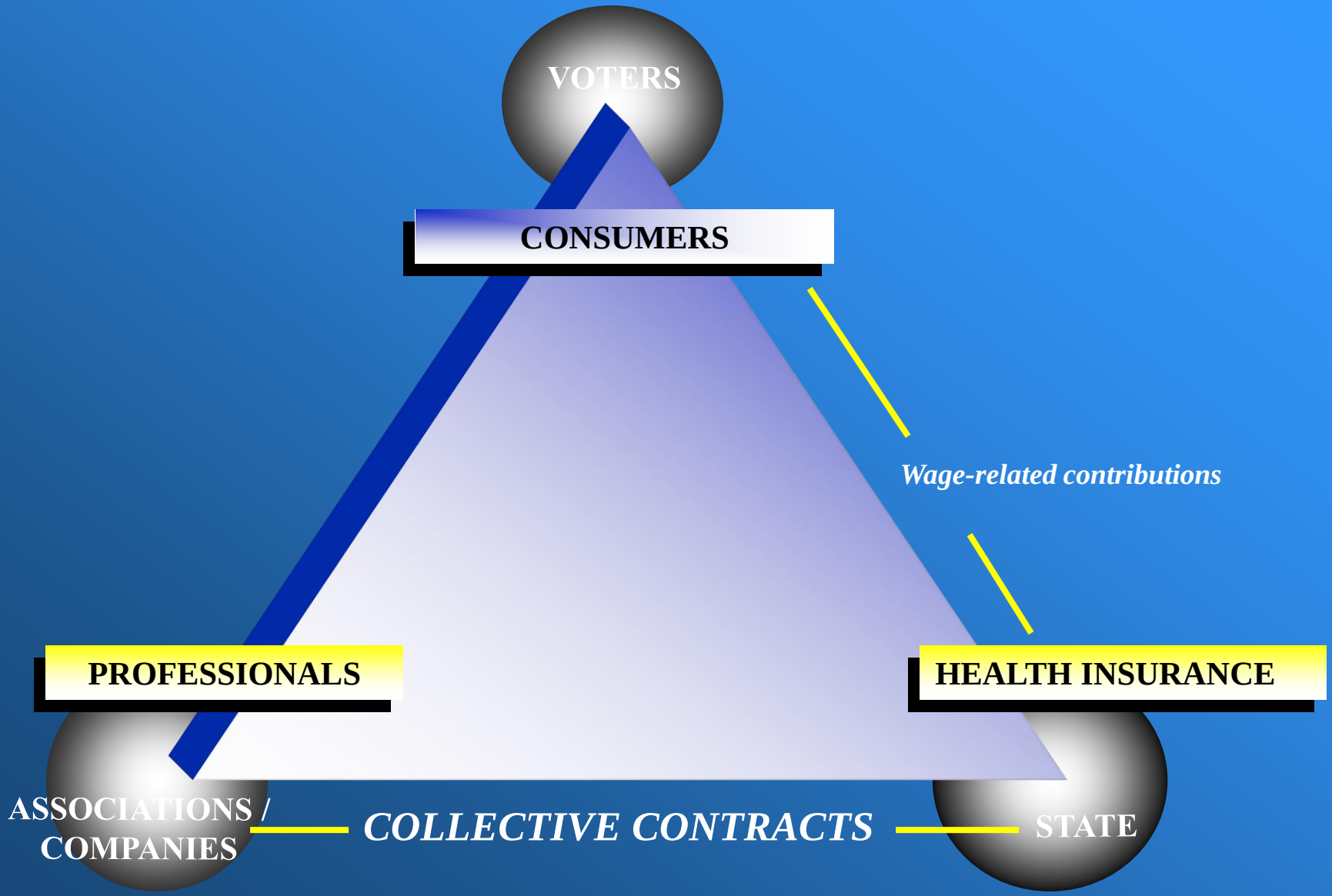
National Health System and Decentralisation

** England 1999-2002-2003*



Converging Dynamics of Change

Professional and Democratic Logic



Practice of More Global Medicine

Demands the creation of

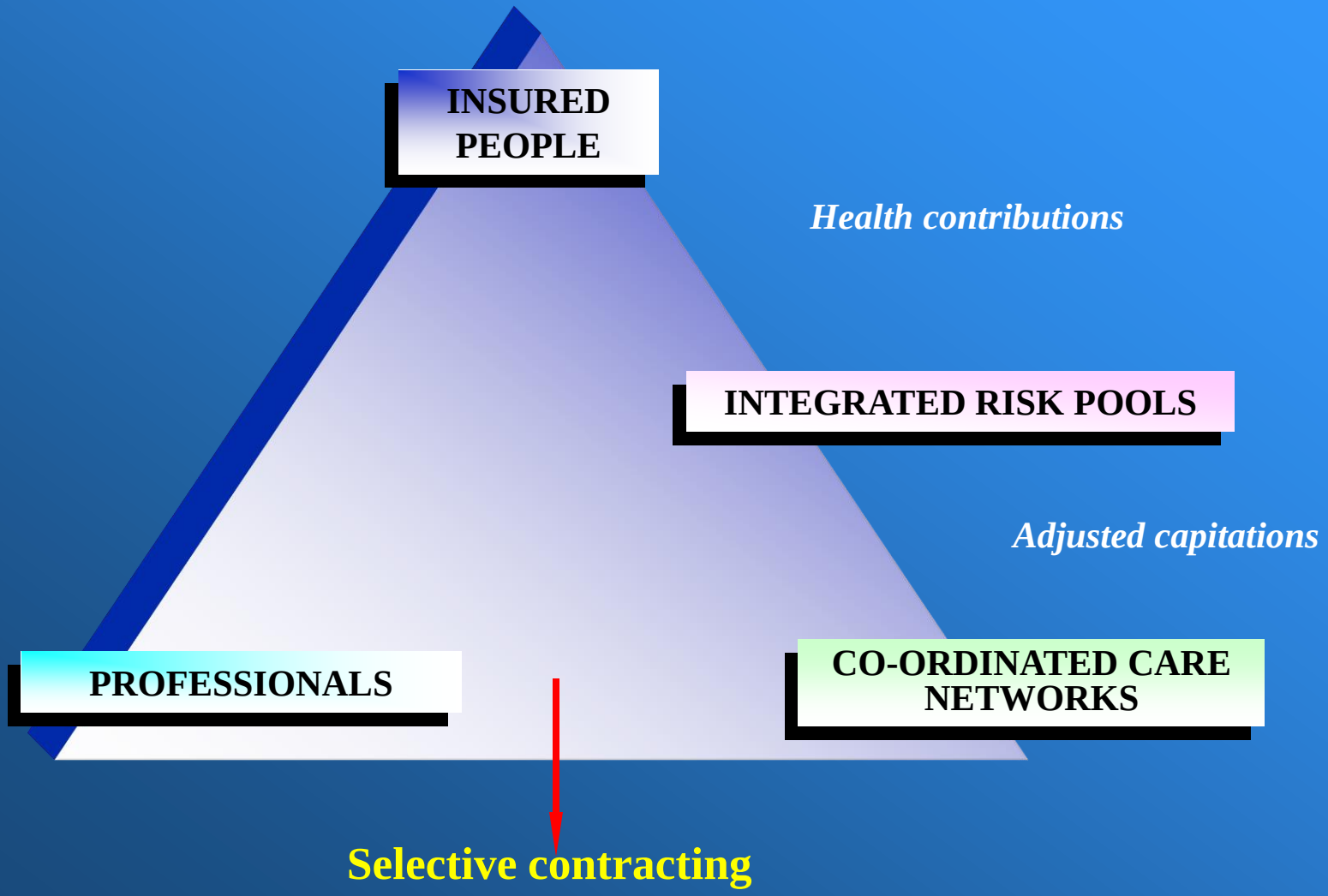
Recording, **C**linical, **H**umanist, **E**conomic and **S**ocial **H**ealth **I**nformation

in the context of

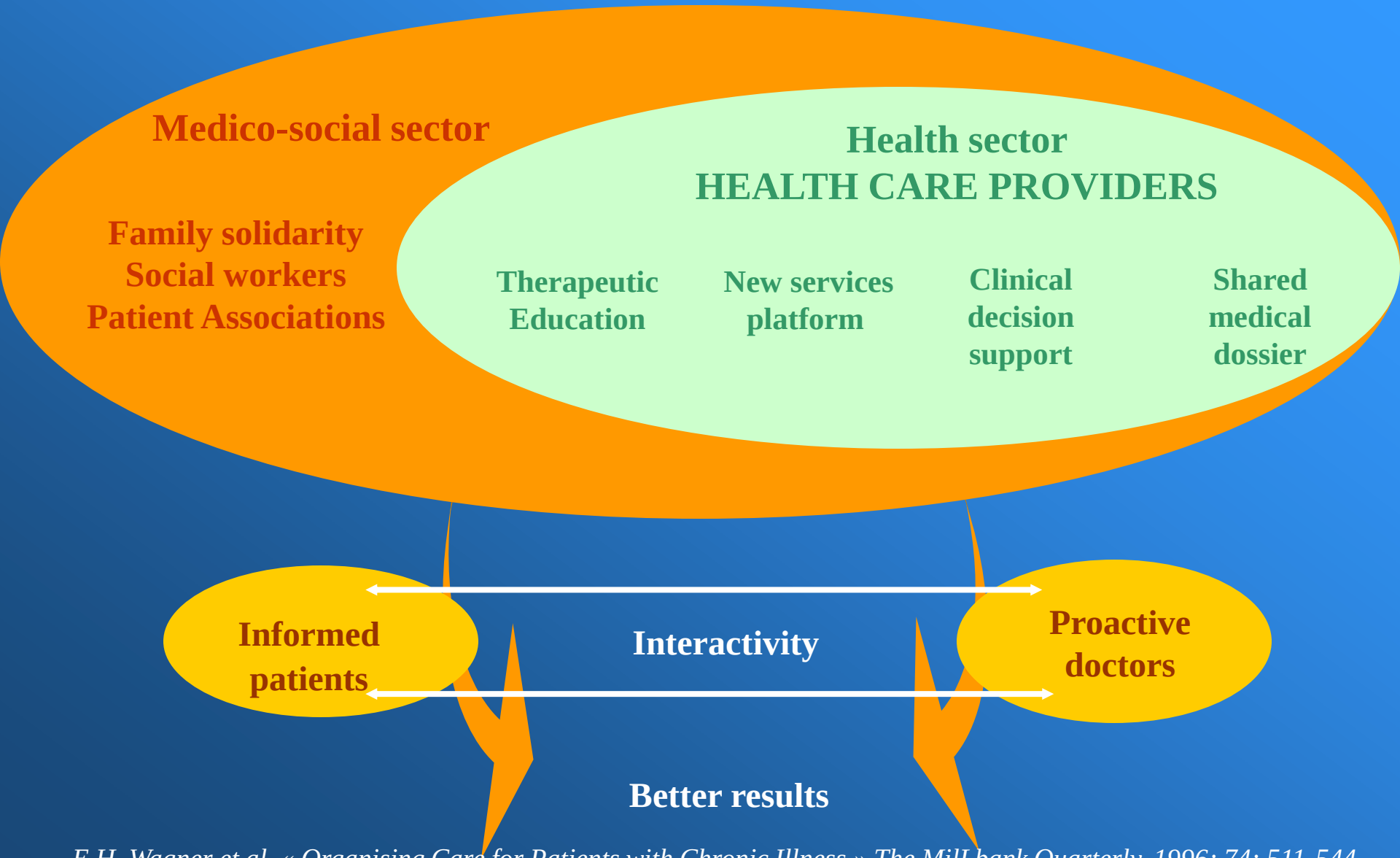
everyday medical practice

Universal Cover and Co-ordinated Care Networks in Competition

** Krakov, Hausarzt Model (Frankfurt on Main), Diabetes Model (Thuring), Vorbaten Model, RSC (France)*



Networks: Another Idea of Care



E.H. Wagner et al. « Organising Care for Patients with Chronic Illness » The MilLbank Quarterly. 1996; 74: 511-544

The Quality Process: At the heart of Network Management

Co-ordinated Care Network

Quality Improvement Unit

Missions:

- **To educate patients,**
- **To train practitioners,**
- **To share information,**
- **To evaluate practices,**
- **To feedback information,**
- **To manage risk.**

Organisation:

- Presence of a **medical leader,**
- **Quality circles** in the areas which pose problems, bringing together practitioners and care workers under the control of a budget leader.

New Service Platforms

- **GP regulation of emergencies**
- **Medical on call establishments**
- **Day hospitals, home care**

Adapted from Inspection Générale des Finances, Enquiry Report No. 2002-M-023-02

With New Assessment Criteria

- ***Clinical Impact: observational efficacy***
  - Variability of practices
  - Quality of compliance
  - Control and non-control of disease
  - Effects of education and training
- ***Human Impact: benefits to life provided***
  - Reduction in symptoms
  - Reduction in functional handicap
  - Improvement in quality of life and satisfaction
- ***Economic Impact: change in costs***

What a Co-ordinated Care Network (C.C.N) is Not

- A health maintenance organisation (HMO)
- A polyclinic or health centre
- A Professional Sector or system

What it is

« The network is a **structure** grouping together healthcare professionals, **facilitated by the family doctor** chosen by the patient, who dispenses all of the care required by a population the amount of which is quantitatively set in advance;

in return for an **overall annual sum,** set in advance, financed in part by the Social Security and in part by the insured person ».

R Launois . « les Réseaux de soins coordonnés, un projet de réforme du système de soins » Assemblée générale de l'Association de Genève. The Geneva Paper on Risk Insurance 1987; 12: 345-349

How is it Financed?

- Each network freely sets the sum for the overall management of a subscribing member
- The National Health Insurance Funds pay an **A**nnual **H**ealth **S**um which varies depending on the age and sex of the person
- The subscribing member pays the difference between the total sum and the National Health Insurance Funds sum. He or she pays this in advance. This establishes a competing dynamic situation.

Accountability

- Cost constraint is introduced at the level where decisions are made,
- Procedures for managing the clientele are changed,
- The responsibility of providers is clearly established: gains or losses at the end of the year are shared.

Solidarity

The *monopoly* of the Social Security system is ***maintained.*** Only the methods of payment of services are changed.

TRIPLE SOLIDARITY:

- Solidarity ***within*** a class of risk between the well and the ill
- Solidarity ***between the classes*** of risk within the network
- Solidarity between the ***rich*** and ***poor*** on a community basis.

Contestability

- Between the CCN for their potential subscribers. The CCN which has the best quality/personal contribution ratio attracts the clientele.

- Between health care professionals for the CCN. If a producer is too expensive the network will have to increase its prices.

- Between the CCN and the rest of the health care providing system; nothing is imposed.

Expenditure on Consultations in the Control Group and in the Experimental Group Before and After Experiment, Per Consumer, Per Year

(Atlantic Pyrenees Region) €

	Control Group (n=1116)			Experimental Group (n=1373)		
	1999	**2000**	**%**	**1999**	**2000**	**%**
GP	151.69	163.73	**7.9**	135.25	122.11	**- 10.1**
SP	325.48	293.92	**- 9.7**	292.55	278.07	**- 5**
TOTAL	**477.17**	**417.55**	**- 4.1**	**428.38**	**400.80**	**- 6.6**

Source : REES France - Mutualité Sociale Agricole des Pyrénées Atlantiques

Structure of expenditure on Generalists Prescriptions Before and After Intervention in the Control Group and on the Experimental Site

(Pyrenées Atlantic Region) €

	Control Groupe			Experimental Group		
	1999	**2000**	**%**	**1999**	**2000**	**%**
Pharmacy	381.43	433.57	**13.7**	380.67	387.07	**1.5**
100 %	*2.9*	*2.9*	***+ 2.9***	*9.76*	*8.84*	***- 11.8***
65 %	*332.03*	*377.31*	***+ 13.6***	*326.85*	*338.13*	***+ 3.4***
35 %	*46.5*	*53.20*	***+ 14.6***	*44.21*	*39.79*	***- 9.9***
Auxillary care			**+ 28**			**- 17**
AMI	*34.91*	*46.04*	***+ 32.1***	*21.65*	*17.07*	***- 21.5***
AMK	*19.36*	*23.48*	***+ 21***	*21.65*	*18.9*	***- 12.5***
Others	68.75	86.29	**+ 25.5**	74.7	60.67	**- 18.8**
TOTAL prescriptions	**537.84**	**627.94**	**+ 16.8**	**532.5**	**514.21**	**- 3.1**

Source : REES France - Mutualité Sociale Agricole des Pyrénées Atlantiques-Groupama Partenaires Santé

The Advantages of the Co-ordinated Care Networks

- Cost-consciousness for the user
- Making producers financially responsible
- Maintaining quality through competition
- Solidarity safeguarded

Conclusion

Regardless of the **future** of our social protection system,

whether it progresses towards an **administrative rationing system**,

or towards the introduction of a **health quasi market**,

in the 21st century health care services will be inevitably **structured around the concept of the network.**