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Review

Managed care in four managed competition OECD health systems

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ABSTRACT

Managed care emerged in the American health system in the 1980s as a way to manage suppliers' induced demand and to contain insurers' costs. While in Israel the health insurers have always been managed care organizations, owning health care facilities, employing medical personnel or contracting selectively with independent providers, European insurers have been much more passive, submitting themselves to collective agreements between insurers' and providers' associations, accompanied by extensive government regulation of prices, quantities, and budgets. With the 1990s reforms, and the introduction of risk-adjusted "managed competition", a growing pressure to allow the European insurers to manage their own care – including selective contracting with providers – has emerged, with varying speed of the introduction of policy changes across the individual countries. This paper compares experiences with managed care in Israel, The Netherlands, Germany and Switzerland since the 1990s. After a brief description of the health insurance markets in the four countries, we focus comparatively on the emergence of managed care in the markets for ambulatory care and inpatient market care. We conclude with an evaluation of the current situation and a discussion of selected health policy issues.

1. Introduction

In response to market failures originating from a combined indemnity insurance and FFS providers' reimbursement system, other modes of interactions – commonly termed "contracts" – between insurers and providers have emerged in the 1980s American health system. These contracts have been replacing, to various degrees, the classical, anonymous, temporary and market-based FFS transactions, resulting in vertically integrated insurer-provider organizations, and are believed to alleviate the burden of the major components of the relevant market failures [1,2]. Managed care contracts account for over 80% of the American healthcare market. Medicare and Medicaid, the public agencies, were the first to allow for managed care practices. These practices include two sets of factors: with regard to the enrolees, closed panels of providers, preferred providers, incentives to patients to use networks and disease management programmes, and allowing patients to use supplemental insurance or additional topping up methods to increase choice, are used. With regard to providers, negotiation between an individual insurer and provider about price and quality, use of quantity and quality monitoring and incentives, linked or unlinked to quality measures, and selective contracting, are used. The first set of factors enables the managed care organization to contain

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costs at the expense of limiting consumers' choice. The second set of factors enables the organization to monitor providers' moral hazard while assuring good reputation, at the expense of individual provider's autonomy.

On the other side of the Atlantic, European insurers (or sickness funds, as they are called in some countries) and providers have been much more passive, submitting themselves to collective agreements between insurers' and providers' associations [3]. These were largely inspired by a strong concern for cost control and market failures in the health services market, leading to extensive government regulation of prices, quantities, and budgets. With the 1990s reforms, and the introduction of risk-adjusted "managed (regulated) competition" among insurers and sickness funds within the framework of national health insurance, a growing pressure to allow the insurers and sickness funds to manage their own care – using the managed care tools described above – has emerged, with varying success in terms of policy changes across the individual countries.

This paper compares experiences with managed care and selective contracting in Israel, The Netherlands, Germany and Switzerland. Prior to the reforms, the roles of health insurers had been markedly different in the four countries. In Israel, the health insurers have always been managed care organizations, owning health care facilities, employing medical personnel or contracting selectively with independent providers. In the other countries, health insurers had a passive role because contracts were bargained collectively. Since the 1990s, different market oriented reforms have increased their incentives to act as prudent buyers of care [4]. Health insurers can improve efficiency mainly by designing innovative contracts with health care providers. The primary interest in this paper is how managed care including selective contracting has developed during the last 25 years, and, as much as possible, to trace the effect of this development on containing health care expenditures while ensuring access to high quality care. As policy makers around the world are working on health reforms, it is important to know how managed care has contributed to efficient provision of high quality health care services.

The analysis starts with a description of the health insurance markets in the four countries in Section 2. In Sections 3 and 4, the provision of health care is described, first, the markets for ambulatory care, followed by the inpatient market. In Section 5, we broadly evaluate the current situation and discuss health policy issues. Section 6 concludes the paper.

2. Managed competition and managed care in health insurance markets

2.1. Introduction

All four countries introduced, while reforming their healthcare system, the structure of regulated (managed) competition [5]. Health insurance for the total population is mandatory for a 'basic' package of health care services and pharmaceuticals defined by the government. Managed competition means that health care within the package is actually offered by independent insurers competing in a market regulated by the government (as opposed to a private insurance market, which functions almost freely). Crucial regulations include open enrolment, premium rate restrictions and risk adjustment between insurers. The rationale for this arrangement is to stimulate the insurers to improve efficiency in healthcare production and to respond to consumer's preferences, while still maintaining affordability, solidarity, and equal access to high risks.

With the introduction of (managed) competition among insurers, insurers faced the pressure to be more efficient in order to survive the competition. As was mentioned above, managed care is one of the main ways for insurers to contain cost and gain efficiency in the provision of care. With the introduction of (managed) competition among insurers, insurers faced the pressure to be more efficient in order to survive the competition. As was mentioned above, managed care is one of the main ways for insurers to gain efficiency in the provision of care. Insurers can hardly differentiate themselves from competitors in a market with standardized benefits without using at least some elements of managed care. Therefore, the system of managed competition is unlikely to achieve its goals of efficiency and affordability without some form of managed care or selective contracting being applied by insurers.

The following subsections describe the managed care scenarios in the managed competition framework in the four countries. We focus on the actual arrangements that have emerged in different parts of the health care delivery market.

Table 1 presents some background national details and the highlights of the discussion in this section. An important socio-cultural related issue is the level of satisfaction of consumers and providers (mainly physicians) with the development of managed care. This issue is discussed in Section 6.

2.2. Israel[1]

The Israeli experience with regard to managed care and selective contracting is quite unique in that health insurers (sickness funds), since their establishment, have always been Managed Care Organizations (MCO), variably integrating the insurance and provision functions, and using various forms of contracting with providers. The Clalit Health Services (CHS), established in 1911, was probably the first MCO in the world, providing care through its own hospitals and salaried physicians and health professionals (somewhat similar to the American staff model HMO). Subsequent sickness funds, established in the 1940s, chose a different care management, and contract selectively with independent providers, physicians and hospitals. Until 1995, the sickness funds market operated as a private, essentially unregulated health insurance market, characterized by risk selection with severe adverse financial effects on CHS. However, since the CHS had, before 1995 when the National Health Insurance Law was enacted, an

[1] The Israeli data and information in this paper is largely based on the Ministry of Health data and on Rosen et al. [38].