

12.26 1. CP Statement on managed Care

(CP 1999/067 Final)

1. Introduction

At the April 1998 session of the CP, the UK delegation was asked to produce a paper on “managed care”. The resulting discussion paper, CP 98/80, was considered by the Subcommittee on Organisation of Healthcare, Social Security, Health Economics and the Pharmaceutical Industry in September 1998 and a working group was set up, co-ordinated by the UK delegation and involving representatives of the German, Dutch and French delegations. To provide the group with information on which to base its work, all delegations were asked to respond to the six questions posed at the end of CP 98/80. Ten delegations (including one observer delegation) did so, and a summary of responses was circulated as CP 99/24 and discussed briefly at the April 1999 subcommittee session.

There were no further responses or comments, and so the working group prepared a draft statement for consideration at the September 1999 subcommittee session, drawing on the two documents previously mentioned. The statement was approved, with minor alterations, for submission to the General Assembly in November 1999.

2. Proposed CP Statement

2.1 Definition of “Managed Care”

The standing Committee of European Doctors (CP) recognises that “managed care” is a term used frequently to describe a broad range of concepts and most often to describe a specific system of health care delivery in the United States of America (USA). For the purposes of this statement, however, we define as “managed care” those circumstances where a third party – besides the doctor and patient – is involved in the primary process and in a position to influence patient choices or doctors’ decisions. The stated aims of the third party will generally be any one or all of the following – to control costs, to improve the quality of care to rationalise its provision.

2.2 “Managed Care” in European Health Care Systems

Although European public health care systems differ both in funding methods and in delivery, they are all underpinned by one fundamental principle – best described as solidarity. This means, essentially, that all citizens will have an equal right to treatment on the basis of clinical need, and that the tax or insurance contributions of the better off will be used as

necessary to subsidise the treatment of the less well off. The CP affirms its strong support for this fundamental principle.

All health care systems are currently facing similar pressures – rapid technological progress leading to rising demand in the face of limited resources. All health professionals are under pressure to deliver the most effective treatments possible in the most cost-effective way possible and to be accountable for their actions. Equally, there is an increasing recognition that health professionals, patients, health care insurers and governments all have a shared responsibility for health care of high quality. Whether they work for centrally funded and administered health services, or have contracts with insurance companies, health professionals will be subject to some degree of third party influence. Thus, all European health care systems are already “managed” to some extent.

Many so-called “managed care” features will be long-established and well-accepted by patients and professionals alike, or they will clearly be sensible and desirable – increased emphasis on prevention, for example, or the development of evidence-based medicine where applicable. Others are more contentious, and – given the cultural diversity within Europe – what is acceptable within one health care system may not be acceptable within another. “Gatekeeping”, i.e. the control by general practitioners of access to specialist treatment, is one subject on which views have long differed. Measures in which commercial or financial interests are seen to threaten or override clinical judgement are, however, *always* unacceptable.

It is important to select and encourage those positive elements which will benefit European health care systems while rejecting those which will damage patient care and undermine the doctor-patient relationship.

2.3 Potential Benefits of “Managed Care”

A co-ordinated approach to health care can bring many benefits, and ensuring that the best practice is available to all. Some of the desirable aspects of the “managed” approach, drawn from experience in CP member countries, are as follows:

- Incentives to use evidence-based medicine, where applicable, and to promote best practice by means of clinical guidelines – while still allowing doctors to use their own judgement;
- Increased evaluation of the effectiveness of treatments;
- Increasing emphasis on improvements in professional training and continuing education;
- Improved co-operation between the primary and secondary health care sectors and between doctors and other health professionals;
- Greater involvement of patients in treatment decisions;

- Clear identification of prevention as an integral part of health care strategy;
- Co-ordinated approach to the financing of prevention, treatment and social care;
- Creation of a single health record for patients, where this does not already exist.

2.4 Negative Consequences

Much of the criticism levelled at “managed care” schemes in the USA is based on fears that they have sought to control costs and demand at the expense of patient choice, clinical autonomy and optimal care. They have sometimes created serious conflicts of interest for doctors, who may be offered incentives for reducing their use of certain services.

The CP wishes to retain what is best in European health care systems and therefore considers the following *unacceptable*:

- Potential exclusion from insurance programmes of patients who are “bad risks”;
- “Gag rules”, whereby doctors are prevented from informing patients about expensive treatment not covered by insurance programmes;
- Improper design, or use, of protocols and guidelines as a means of coercion or even rationing;
- The use of disease management packages to oblige doctors and patients to use certain pharmaceutical brands;
- Health care run for profit, with the result that resources which could be made available for patient care are diverted;
- Monitoring of doctors’ practice without appropriate medical input;
- Inappropriate moves to encourage other health professionals to take on tasks normally performed by doctors – e.g. diagnosis or prescription;
- Measures which encourage doctors to limit the time spent with, or care given to, patients, thereby undermining the doctor patient relationship.
- A perceived tendency to encourage doctors to compete for limited resources, rather than cooperate;
- Increased bureaucracy and “red tape”.

2.5 Conclusions

The CP’s 1994 statement on *ethical and economic consequences of the limitation of resources for health care* affirms that *the first task of the medical practitioner is to act in the best interests of the patient.*¹ Doctors are responsible for giving patients the best possible advice about treatment in accordance with scientific knowledge and experience, but they also have an obligation to manage the resources available to them as efficiently as possible and to administer treatment as cost-effectively as possible. Autonomy and accountability are compatible; in return for the professional autonomy which doctors enjoy, they must be prepared to account for their actions and to

implement robust and transparent self-regulation measures.

The CP affirms the commitment of the medical profession in Europe to demonstrate its accountability in return for its autonomy, to work with patients, and to share responsibility for identifying best practice, maintaining and improving standards and containing costs where it is possible to do so without harming patients. The many initiatives already underway in areas such as continuing medical education and professional development (CME/CPD), the development of clinical standards and guidelines, peer review, quality assurance and clinical audit, illustrate the seriousness of this commitment.

Cost control is important, but should never be at the expense of quality. We call on governments, insurance bodies and other “third parties” to work with the medical and other professions and with patients to build on what is best in European health care systems and to avoid those aspects of “managed care” which may damage the interests of patients.

12.27 Resolution “Alternative Professional Fields”

(CP 1999/083 Final)

Unemployment amongst doctors exists in many European Union Member States. Analyses show that such unemployment affects in particular young doctors at the start of their professional activity and also older doctors, who have exercised their profession for many years and who, for several reasons, now wish to give up their conventional profession and seek alternatives.

The CP member organisations have already taken action in the past to create a counterbalance between different countries with high levels of unemployment amongst doctors and countries that have a shortage of doctors by promoting migration.

However, in the long term, it will not be possible to prove that there are positions for all doctors looking for employment solely by promoting migration. For this reason, “alternative fields of employment” will be of particular importance in future. These are professional fields that are not part of traditional medicine close to patients, in which however a qualification after a course of medical studies or even many years of professional experience as a doctor are both useful and advantageous.

However, it must regrettably be stated that many doctors affected by unemployment are not adequately prepared to take on such “alternative professional activities” and cannot meet the requirements. The reasons for this are to be found:

- in the structure of training for doctors at universities,
- in the inadequate range of additional courses of