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Chapter 11. When complementary health insurance organisations invest in occupational health prevention

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During the 2010s, when all employers in France were required to provide complementary cover for their employees (law of 23 December 2013 on the financing of Social Security), complementary health insurance organisations (OCAMs), i.e., mutual insurance companies, provident institutions and insurance companies, started to develop new occupational health prevention offers, thus integrating a legal environment that establishes the company as a space for negotiation on the issues of quality of life at work (Dirringer, 2019).

In this context, the OCAMs are positioning themselves as new agents in the prevention of employee health (Marié, 2017), this has been very little studied, except for certain insurance offers (Juston, Ginon & Del Sol, 2019). Although, the cost of prevention offers is marginal in the choice of contracts within companies, they none the less affect the prevention practises and capture part of the budgets and actions carried out in companies on these issues. Not only can health insurance contracts include prevention actions, but prevention offers can also be proposed in addition to the insurance contract. So how does the development of these offers transform the prevention ultimately offered to employees ?

We will first look at how OCAMs are positioning themselves in the field of occupational health (1). Although they remains peripheral, these health insurance actors are contributing to the diversification of the preventionists mobilised and fuelling the market for occupational health advice and services. Competing with the traditional actors, they position themselves as middle-men and through their offers modify the preventive measures set up in companies.

Secondly, we will look at the employees' side of the equation by studying the occupational health services offered by the OCAMs, their development and their diversity. Harmonised within common programmes, they are part of representations of prevention which are not shared by all occupational health preventionists (2).

Box1: Methodology

The survey, conducted within the MaRiSa research project financed by the ANR (l'Agence nationale de la recherche), took place from September 2019 to January 2020. In addition to a documentary study of the main occupational health prevention offers of French OCAMs (Vyv, Malakoff Médéric Humanis, AG2R La Mondiale, Harmonie mutuelle, MGEN, CHORUM, Aesio, MBA mutuelle, Groupe Pasteur Mutualité), this work is based on twelve semi-structured interviews conducted with people in charge of occupational health prevention within the OCAMs (prevention officers, partnership and marketing managers, etc.). Four interviews were also conducted with institutional players in occupational health prevention : a regional institution under the supervision of the Ministry of Labour for the improvement of working conditions (ARACT), a labour inspector, the management of an occupational medicine service, and a consultancy firm specialising in measuring absenteeism. The observation of a round table organised by a vocational training management fund (FONGECIF) in June 2019, on the subject of health at work and bringing together professional and mutual support actors, completes this study.

1. Positioning yourself in occupational health prevention

Although they remain marginal in their action, OCAMs have historically contributed more to public health prevention campaigns than to occupational health. At the end of the 1990s, the development of responsible contracts obliged them to fully refund preventive measures and encouraged the emergence of these issues, particularly within mutual insurance companies. However, since the generalisation of group contracts, OCAMs have been investing in the occupational health prevention market by developing new offers for their corporate clients. They are therefore competing with existing occupational health prevention institutions (1.1) by professionalising the prevention officers within them (1.2).

1.1. Competition with institutional preventionists

In France, since the middle of the 20th century, occupational health prevention for employees has mainly been provided by occupational physicians, themselves employees of companies or employed in services financed by employers' contributions. Companies with a high incidence of occupational accidents and diseases are also monitored by occupational risk inspectors and prevention specialists from the Social Security pension insurance funds (CARSAT). For their part, the OCAMs with the exception of provident institutions offering services tailored to the occupational risks of the branches, were outside the field of occupational health prevention.

However, a market for expertise and advice on occupational risk prevention is gradually developing among employers and trade unions (Cristofalo, 2012). Occupational health services were also reformed in the 2000s to include non-medical professionals (hygienists, ergonomists, nurses, psychologists, etc.) and called "occupational health services" (Rivest, 2002). In addition to medical examinations, actions on the environment and on working conditions are given greater importance. Although this reform mainly concerns the management of these institutions (Barlet,

2019), it allows the emergence of “complementary services” invoiced to employers in addition to their contributions. These services were recently recognised to strengthen occupational health prevention by the law of 2 August 2021.

It is on this market of occupational health advice and prevention that OCAMs step in by developing occupational health prevention offers, some of which are invoiced to clients in addition to the premiums paid under the insurance contract. As these OCAMs, thanks to numerous mergers, are becoming organisations that can cover millions of people, they are supported by the public authorities, which legitimise their role in this area, recognised as new “contributor[s] to occupational risk prevention and health promotion” (Lecocq, Dupuis & Forest, 2018) and associated with occupational health prevention policies. For example, the public authorities recognise their role in the National Occupational Health Plan (2021-2025), which is regionally adapted and sets the main guidelines in this area.

In this context, the arrival of the new actors issued from the OCAMs in the field of prevention has called into question the place of the traditional players and raised issues of competition (Draper, 2003). Doctors feel threatened within occupational health services, more so than their management, particularly those in favour of liberalising the occupational health market who value opening up to competition. As one occupational health physician put it to a prevention manager from a large mutual insurance company during a round table organised by a vocational training management fund (FONGECIF) : “Don’t believe it, companies and employers don’t keep us informed of what you are doing [...] I have the impression that it is my work that you have done. [...] If you do this on your own, if you intervene in companies and I am there, what do I do ? I feel I’m useless”. Legitimacy issues are at stake with employers who choose, authorise and even finance these interventions in companies. From then on, the OCAM professionals in charge of occupational health prevention ensured their position by placing themselves as middlemen between preventionists and client companies.

1.2. OCAMs : middlemen between preventionists and companies

Departments dedicated to prevention, considered as an additional service, are relatively recent and marginal within OCAMs. As prevention is closely associated with the brand image of OCAMs, these issues are often handled by the partnership managers or the marketing strategy department. In an extremely competitive and difficult employee health insurance market, which is governed by numerous rules and legal provisions (calls for tender, collective branch agreements, etc.), the prevention offer is therefore the subject of considerable communication. These teams are also close to the social action departments with which prevention is generally associated. During the 1990s and 2000s, prevention was promoted through thematic public health campaigns carried out jointly with mutualist representatives. But with the generalisation of group contracts and the development of offers for companies, this prevention became more professional.

In one of the health care mutual designated as a pioneer in this field, the department dedicated to prevention has existed since the mid-2000s, but in the other OCAMs, the teams have been more developed since the 2010s. The OCAMs’ internal services, which vary in scope, are now

coordinated within the social protection groups. In one of the health care mutual unions insuring around 11,000,000 people in 2019, about fifteen people are directly responsible for these issues and interact with about fifty prevention officers (from one person to several dozen per OCAM). In another social protection group, some forty employees are involved in occupational health activities.

When they were first set up, these departments recruited former sales staff or account managers who wanted to diversify their activities. Faced with their lack of knowledge of occupational health issues, OCAMs – or even the groups to which they belong – resort to specialised institutions, such as the establishments for the improvement of working conditions under the supervision of the Ministry of Labour (ARACT), or to continuing education in engineering schools (CNAM), to train these employees in these new issues. In addition, in order to gain legitimacy, OCAMs are increasingly recruiting people with a Master's degree in public health, or directly in occupational health specialities in human and social sciences, human resources or statistics, thus changing the profile of prevention officers.

Within OCAMs, they generally deal with exchanges with client companies to present the systems, define their expectations, the scope of possible interventions, the use of risk assessment tools and receive their feedback. However, apart from a few exceptions (for instance a mutual insurance company which we studied), they usually subcontract prevention actions in companies and the development of risk prevention tools.

The two main social protection groups mobilise networks of independent specialists according to the risks identified to provide their services. One of them uses a network of consultants specialising in psychosocial risks and approved by the agency for the improvement of working conditions (ANACT) under the supervision of the Ministry of Labour. Each OCAM also resorts to and locally certifies workers that they have been using for several years for their public health actions. The other social protection group, seeking to address a large number of clients, uses about ten firms (one or two per subject : musculoskeletal disorders, psychosocial risks, road risks, physical activity, etc.). The choice is made by the member companies, which pay for the interventions and contract directly with the OCAM's subcontractor.

In addition, OCAMs include the use of tools for measuring and acting on employees' health (software for analysing absenteeism based on company data, assistance in drawing up compulsory occupational risk assessment documents, coaching applications, etc.) in their occupational health prevention offers. These are developed and sold by subcontracting companies. As suppliers of clients for the professionals they bring in, OCAMs have a middlemen's role in the occupational health prevention market, helping to define the actions set up in companies. They must therefore adapt their offer in this area.

2. Offers to build customer loyalty

The idea that prevention helps to reduce risk and benefit consumption seems to be more of a commercial argument than a belief shared by insurers. Prevention is above all a differentiating factor in a highly competitive market where the OCAMs offers are similar. Because

the complementary social protection market is highly regulated, there is very little room for manoeuvre in terms of price. Prevention is therefore a way of convincing customers to renew their contracts or, even better, to change OCAM. It is unthinkable today for an OCAM not to offer occupational health services, and differentiation is based on the quality of partnerships and marketing. This loyalty is achieved by organising a “tailor-made” offer sold as being adjusted to the needs of clients (2.1), who are above all employers and management teams ; consequently, the prevention offered is in line with their interests (2.2).

2.1. Harmonising a diversity of schemes

The offers most closely tailored to professional risks are those of joint provident institutions or mutual insurance companies specialising in specific sectors of activity (social economy, for example). These OCAMs generally set up observatories (within foundations which allow part of the contributions to be tax exempted) to find out about health conditions within the professional branches. These observatories, apart from being a marketing tool to display the annual amounts devoted to prevention, make it possible to better manage the claims experience of the populations covered. Within the framework of branch agreements, funds dedicated to social support and prevention can now be set up. However, they pay for social action (aid for members in economic difficulty) rather than prevention.

Among the existing preventive actions, a social protection organisation which has been dealing with the bakery branch for about ten years has set up oral and dental prevention programmes involving the organisation of visits with dentists, training courses provided in apprentice training centres or the prevention of sleep disorders through the setting up of training and coaching. Although aimed at a public of (future) professionals and adjusted to the risks of the profession, these preventive actions essentially deal with individual practices and not the organisation of work.

The more general offers aimed at a variety of companies in different sectors of activity are presented as “tailor-made”. Client companies can then mobilise some of the measures presented in a programme according to their choice. The prevention officers intervene in the company to assess the needs of the clients and the resources they wish to allocate to these actions, and then guide them towards the measures that seem most appropriate.

Box2: The obligation to negotiate quality of life at work

In France the national interprofessional agreement of 19 June 2013 on the quality of life at work introduces an obligation to negotiate on the subject in companies. Following on from the “quality in work” promoted by the European authorities (Davis & Chermis, 1975; Commission of the European Communities, 2001) and the action of the agency under the supervision of the Ministry of Labour for the improvement of working conditions (ANACT) in the 2000s, this agreement is part of a shift, in France, from the notion of malaise at work to that of employee well-being seen as a factor in company performance and economic efficiency (Renard & Zimmermann, 2020).

In a context where the company is becoming a forum for negotiating on the quality of life at work, many OCAMs are taking up the challenge of “well-being” in the company and are offering appropriate products via their group contracts. As a programme manager from a social protection group points out, “we have made something new out of something old”. Like a major mutual insurance company, the people who define the programmes recycle the thematic public health campaigns already set up in the 2000s, for example on diet, sleep, stress management, addictions or road risk. These campaigns, which have been adapted locally into workshops or conferences offered individually to policyholders, are now offered to employees via their employers. These awareness-raising modules are presented as a response to the main occupational health problems and causes of work stoppages, namely musculoskeletal disorders and psychosocial risks (Berard, Oustric & Seiller, 2019).

The prevention officers then mobilise the local networks of people they know (dieticians, psychologists, relaxation therapists, sports coaches, physiotherapists, etc.) to give lectures or run workshops to raise employees’ awareness of these issues. These programmes are common to all the OCAM’s local entities; they thus harmonise the services subcontracted locally to external contributors. If some services are included in the contracts, several OCAMs, which are non-profit organisations, set up approved training organisations in order to be able to market them and for companies to include them in their training plans. Some consultations and training programmes are delivered through e-learning platforms.

While prevention officers strive to build up the loyalty of their customers by developing “tailor-made” programmes over several years and regularly seeking out new features to promote, these offers also make it possible to give coherence to a wide variety of schemes within common programmes. These include offers aimed directly at employees: access to a network of “alternative” medical care, assistance in the event of an accident, social action services (help with home care, etc.), awareness-raising activities and training. Measures are also offered to employers: self-diagnosis of occupational risks, the setting up of vaccination campaigns, support for the return to work of employees who have stopped working, interventions or tools to help assess organisational risks in companies or measure absenteeism. The lifespan of these systems, which are usually delegated to external service providers, is not necessarily very long and depends on the interest aroused in the clients: “we carry out a lot of tests and also things that do not work and then we abandon them”, as the programme manager mentioned earlier points out.

This harmonisation process is also reinforced by the concentration of the complementary health insurance sector, which has led to the merger of OCAMs. The prevention offer is beginning to be reorganised within the groups and it involves pooling the existing offers of each OCAM. First, “tailor-made” programmes with a generalist approach make it possible to reach very different sectors of activity and to bring together prevention officers with different professional cultures. This contributes to the harmonisation of practices and procedures. Then, new offers, pooled together, become accessible to all these OCAMs. The smallest, not having their own prevention offer, can then refer to that of the group. These offers can thus be “industrialised” and made available to a larger number of clients.

2.2. Prevention aimed primarily at employers

Since the generalisation of the obligation for companies to offer complementary health insurance to their employees (law of 23 December 2013 on the financing of Social Security), OCAMs have obtained most of their share of the market via group contracts. While mutual insurance companies used to target individuals more directly (in a “B to C [business to consumer]” logic), the current norm for OCAMs is to reach end-policyholders via the client companies that employ them (“B to B to C [business to business to consumer]”). Although OCAMs claim to be institutions of everyday health-care, the link with individual customers is being diluted. This is especially true since, as a result of mergers and acquisitions, these organisations cover very large populations, which can reach the millions. It is therefore a matter of reaching out to those who determine the choice of OCAMs within companies. As the head of the prevention division of a major social protection group points out, “one potential lever for us in our action strategies is to be more in touch with employers’ issues”.

Once the contracts have been signed and following requests for prevention offers, the people in charge of these issues within the OCAMs meet primarily with the employers or the company’s “human resources” department to define the content of the service provided before presenting it to the staff representatives. Although during the interviews they stressed the importance of mobilising all the players in order to ultimately reach the employees and ensure that the projects are successful, they give priority to the management where their main contacts are.

As elsewhere, the implementation of prevention actions is facilitated in the largest companies, which have more resources (like staff representative bodies, responsible for social, economic and health issues, that exist in companies with at least 300 employees). Tailor-made offers and the implementation of personalised support are therefore more common in these large structures. Small and medium-sized companies, which are often covered by a market intermediated by accountants, are less accessible. As in the case of occupational health services, many OCAMs therefore provide these employers with support in meeting their legal obligations in terms of occupational health and safety. For example, one of the main social protection groups offers a “self-diagnosis” for employers to assess their own compliance with the regulations and an occupational risk assessment tool. These tools complement a range of social action and access to a healthcare network, which are common to all their group contracts.

In order to win the loyalty of the OCAM’s client companies, the offers are therefore geared towards supporting managers (response to legal obligations, absenteeism management tools, etc.). It is above all the company’s performance that is valued, according to the idea that the good health of employees contributes to it: “by having the first prism of looking at the content, the organisation, the meaning of work where we can try to play, improve the performance of both organisations and individuals. However, we do not rule out the possibility of supporting individuals on the issue of well-being”, as the head of the prevention division of a social protection group points out. This loyalty-building strategy is facilitated by the mobilisation of the concept of quality of life at work, which promotes the compatibility of economic and social performance (Levet, 2013). This concept also makes it easier to ignore the concept of suffering at work, promoted by

occupational physicians and highlighting an antagonistic relationship between the search for economic profits and good employee health (Benquet, Marichalar & Martin, 2010).

Many offers of intervention in companies consist, as we mentioned earlier, in conferences or workshops to raise awareness among employees, with the aim to make them change their habits and guide them towards “good practices” which would be the responsibility of individuals. For example, the response given by a provident institution to the risks associated with night work conceals its organisational origin (the disruption of biological rhythms due to staggered working hours) : “Making rounds, if they are watching, for example, they tend to stay seated all night. It’s about being able to move around a bit, it’s about being able to eat better, so we make them aware of this”, as a project manager from a social protection organisation explained to me. Thus, the OCAMs, through the offers they make, disseminate a normative discourse on health on the one hand and, on the other, prevention practices based on individual responsibility rather than on collective approaches. In this respect, they differ from traditional preventionists who seek to act primarily on the organisation of work in order to eliminate risks. This behavioural approach (see chapter 10) contributes to the shift from the employer’s obligation to prevent any deterioration in the health of employees as a result of their work, to the responsibility of the employees themselves in the prevention of occupational risks.

Faced with criticism from preventionists about the ineffectiveness of quality of life at work measures in terms of occupational risk prevention, some people responsible for developing OCAM offers present the notion as outdated : “Put in green plants, ping-pong tables, nap rooms and then that’s it, we’ve solved the problems in terms of quality of life at work... That’s why I think the term is a bit overused” (programme manager of a social protection group). But the prevention officers of many OCAMs still perpetuate practices and systems marked by a culture of health prevention based primarily on a behavioural approach, denying the organisational origin of the disease.

Although the arrival of OCAMs on the prevention consultancy market is marginal and these services are not central to the choice of contracts, a study of these offers makes it possible to observe the changes under way in the field of occupational health prevention. As they are not generally specialists in these issues, the prevention officers within OCAMs act as middlemen, delegating the actual prevention actions to other professionals. Nevertheless, through the architecture of the offers proposed, they contribute to defining the solutions provided in the field of occupational health and thus enter into competition with the traditional actors in occupational health. The “tailor-made” offers of the OCAMs make it possible to harmonise the presentation of various tools and services relating to social action, prevention and advice. The prevention promoted is marked by a public health approach which is based on the implementation of behavioural policies, rather than on effective action on the organisation of work and occupational exposures which cause illness and accidents. The OCAMs’ approach, which aims to win the loyalty of client companies, is favourable to employers in that it helps shift responsibility for risk exposure onto employees. These orientations, which are also endorsed by the law of 2 August 2021 to strengthen occupational health prevention, which seeks to “decompartmentalise public health and occupational health”, lead to a change in the conception of occupational health.

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