Comparing Health Insurance Systems: Constructive and destructive lessons

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Health care insurance reforms in many countries are often framed in terms of negative or positive examples drawn from other countries. How lessons are drawn is of vital concern to health care practitioners, since some of the reforms make things worse rather than better. This essay explores the conditions under which comparative examples help fix problems in health insurance systems (constructive lessons) and when the ideas from abroad contribute to further problems (destructive lessons). Frequently, the United States is used as a model of health care reforms, such as managed care (as an ideal) or as a negative example of how markets lead to health care insurance that many cannot afford. Increasingly, Germany is a source of ideas for reform of countries with employer-based social insurance systems.

The first problem is to understand the nature and context of systems and reforms in other countries. Understanding reforms and system features in health insurance from other countries requires, in turn, an understanding of the context in which they came about. Properly understood, features of health insurance systems can help fix problems in other countries. Such constructive lessons can be drawn even from very different systems. But there are two dangers for observers when trying to draw constructive lessons from abroad: failing to assess the reality behind easy comparisons, and failing to understand the targets and purpose of foreign reforms. Both dangers lead to destructive lessons—applications of solutions that make problems worse rather than better.

The problem of simple assumptions about health care systems is best illustrated by the standard understandings of each system. If one looks at each system at one point in time, it might appear that the insurance system can be summarized simply: private sector health insurance (for the United States) or social insurance (for Germany). Going deeper into the actual features of various health insurance systems, one sees that the value of simple comparisons is limited in face of the complex regulatory and legal framework for health insurance.

In the United States, while private employer-based health insurance covers most people, most health care spending takes place through public health insurance systems (Medicare) in a highly regulated environment more comparable to social insurance systems in most other advanced industrial countries. Fixed prices and a prospective payment system are not only used in Medicare, but private insurance companies base their systems of payments to hospitals and physicians on the rules and prices set in the Medicare system. The public insurance system creates a product in the public sector which can be adapted by the private sector. For physicians, these rates are not negotiated, and the terms of care are set not only by national government commissions but also be each private health insurance company. Each company is also free to deny claims for reimbursement based on internal reviews. The result is a confusing tangle of public and private bureaucratic requirements for claim processing that requires professional help in even the smallest physician practices. The negative example of the United States demonstrates the administrative consequences of multiple private health insurance plans for community health care practitioners.

In Germany, the health insurance system was based on the principle of social insurance guaranteed by equal income-based contributions from employers and employees. Yet in Germany there exists a separate private insurance system

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for people with incomes above a certain limit or outside the normal employment system. These private insurance funds have risk-based premiums, and pay doctors and hospitals over two times the official public health insurance reimbursement rate. Moreover, physicians have the right to offer supplemental services not covered by the public health insurance system to any patient seeking care, and bill the patient directly for those additional procedures (the IGEL system). To survive in a clinical practice, physicians increasingly depend on patients paying extra or privately-insured patients. The German model of allowing people with more resources to pay more either as a supplement to or a substitute for public insurance could be a constructive lesson for health care practitioners seeking to expand the possibilities to sustain an independent practice within the limits of a social insurance system. The two-track system that the private insurance system creates, however, opens the system to criticism from those who prefer to allocate the same health care to everyone.

Too often, the starting point for shopping around for foreign models for reform is to try to contain or cut costs. The problem is that the purpose of major recent reforms in both the United States and Germany is not simply saving money. The United States recently expanded its public insurance system (for the elderly) with new prescription drug benefits (Medicare Part D). Health care spending reached 15% of GDP in the United States, and the Bush administration decided to spend more by expanding the range of benefits for the public insurance system which accounts for most public spending on health care. The main tool for cost control, setting reimbursement prices for pharmaceutical products, was specifically ruled out in the new law. In other words, the reform (as passed) served to patch a hole in public health insurance coverage.

Recent reforms in Germany will attract attention in countries attempting to increase the role of competitive forces in a social insurance system. In Germany, reforms in 2006 were designed to regularize benefits and premiums among public health insurance funds (Gesetzliche Krankenkassen). While this may also save money, it is a more fundamental centralization of the previous system in which public insurance funds had greater freedom to set their premiums based on their own membership. Premiums will now be the same (starting at 15.5% of wages, shared between employer and employee) for all health insurance funds. Among the reforms are new rules that create a new basic benefit package that all public insurance funds and private insurance funds must offer to all. The goal is to reduce administrative costs in the public health insurance funds. Previously each fund was free to determine which benefits it would offer. And while prices had been set by local and regional negotiations between physician organizations and insurance funds, the new system set up a central national negotiating body which includes representatives of patient organizations in addition to insurance funds, physicians, hospitals and government officials. From 2009, a new central payment fund consolidates the premiums collected by each of the over 200 public health insurance funds. In the future, how the costs are shared among different public insurance funds will provide constructive lessons for countries like Japan considering how to best balance premiums and spending from a wide variety of health insurance programs.

In 2009, new health insurance reform initiatives in the United States will attract attention from around the world. The new Obama presidency brings with it the chance for health care reform not seen since the Clinton presidency in 1992. A wide range of measures have been discussed during the campaign, including a focus on prevention and improved data-gathering and sharing among health care providers. Such measures will provide constructive lessons since improving the role of preventive services in health care is a reform goal already agreed upon in most health care systems. Concrete reforms will likely take shape in the United States in the spring and summer of 2009. The stimulus package passed in February 2009 including $19 billion for information technology in health care to encourage standardized electronic patient records. One of the next planned steps is the convening of thousands of public local hearings at which concerns about the health care system will be heard. Such hearings could be a useful way for local health care practitioners to contribute to the general debate about health care issues in countries other than the United States.

Reducing the cost of rapidly rising premiums for private employer-based health insurance will be a priority, as well as providing insurance for the over 40 million people without health

insurance coverage. Some of the reforms will be limited because of the fundamental problem of overlapping jurisdictions, particularly the basic feature by which private insurance plans are regulated by states rather than the federal government. This will explain why some reforms seem so limited despite the obvious failures of the system. The "keywords" that describe these reforms, however, will have to be understood in the context of the limits to reforms. In some cases, destructive lessons can result if the terms are understood as general concepts in health care.

Health care practitioners will likely see concepts developed in other countries applied in reforms locally. Some practices in the process of foreign reforms, for example, widespread public local hearings in the United States, can be constructive lessons even in very different health care systems. New requirements on data sharing on cost and quality, however, may create new demands on community health care practitioners which will also need to be funded rather than simply mandated. Reforms from countries with more competition in social insurance systems (such as Germany) allowing private health insurance or private payment to supplement public insurance benefits may create new revenue opportunities, but will also create new problems in the perception of fairness of medical care which will also need to be addressed. Understanding the context and origin of these measures will help determine whether these reforms will be constructive or destructive outside of their local context.