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STRATEGIC PERSPECTIVES: Learning from other countries' health care systems, Part 1—Is change possible?

By Melissa Skinner, JD

In a recent Senate Subcommittee hearing, Senator Bernard Sanders (I-VT) opened the discussion with this simple thought: The United States has a federalist system of governing where it is common that states learn from what other states are doing, but as a country we do not use that same principle to learn from the experiences of other countries. Senator Sanders made the statement with respect to what we could be learning from other countries' health care systems. Specifically, he stated that "other countries are doing very positive and interesting things," and in his view, "we have a lot to learn," with respect to health care. In that light, he noted that when it comes to cost of and access to health care we spend much more than other countries and relatively, "our outcomes are not particularly good."

While the applicability of other health care systems has long been a topic of debate in this country, it is interesting to pose the question as it was posed in this hearing: What can be learned now that we have passed health care reform and implemented the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148)? In other words, while the debates surrounding health care reform and especially the implementation of a single payer system are not novel in any respect, now that the ACA has been enacted and implemented how can this debate impact the debate about the efficacy of the ACA or the future of our health care programs overall? The purpose of this Senate Subcommittee hearing chaired by Senator Sanders was to consider these very points. A closer look at the expert testimony proffered and the role partisan politics seemed to play during the hearing is telling as to how underlying principles of other systems may be integrated into our current systems to achieve a more balanced and, perhaps, a more widely-accepted system. Yet, this in-depth analysis also reveals the sharp partisan lines that so obviously have been drawn, which may impede any attempt to integrate what can be learned from other countries' health care systems.

The Senate Subcommittee Hearing

Chairman Sanders made these comments during a Senate Subcommittee on Primary Health and Aging's hearing entitled, "Access and Costs: What the U.S. Can Learn from Other Countries." Several experts were invited to this panel to provide testimony on the topic and, in particular, identify the specific aspects of other countries' systems that would work in the American system. The hearing also consisted of additional comments and questions submitted to the panel by subcommittee members Senator Richard Burr (R-NC) and Senator Michael Enzi (R-WY) as well as Senator Charles "Pat" Roberts (R-KS). While Chairman Sanders approached the hearing as a way to examine how to address the statistical discrepancies between cost and access to care in other countries as compared to those measures in the U.S., Senator Burr's approach to the topic stemmed from the presumption that the ACA was broken and ineffective. In his opening comments he stated that before the ACA was adopted he, "warned it was the wrong direction for our country. Health care was broken before [the ACA] but four years later the American people are experiencing first-hand how the new law made things worse." Characterizing the reform as "unprecedented government intervention" into the health care system with "unsustainable costs," he implied—unlike Chairman Sanders who suggested "we have a lot to learn"—that the experiences of other countries might be examples of what not to do. In that light, he argued "the experiences of other countries will reinforce what many Medicaid patients already know, that coverage does not always translate into timely access to care." Although neither Chairman Sanders nor Ranking Member Burr espoused an opinion on what models should be adopted or what specific principles of other systems were a good fit for our country, it became clear even in the difference in opening comments between the two committee members that partisan politics would function as an obstacle in the discussion of what was to be learned by the experts.

The Single Payer Model, Variations and Counterparts

Before considering the experiences of foreign countries in providing health care to citizens and what principles experts have argued may potentially be integrated into further health care reform in this country, a brief review of different health care models is in order. Perhaps what was most widely discussed with respect to health care reform pre-ACA was the notion of a single payer system, that is, a system in which a public agency organizes the public funding of health care for the entire population but where the providers of health care remain private. Yet, many experts have pointed out that a single-payer system is not necessarily subject to one single definition and not many countries can be characterized as pure single payer systems.

The testimony provided to the Senate Subcommittee by Tsung-Mei Cheng, LL.B., M.A., a Health Policy Research Analyst at the Woodrow Wilson School of Public and International Affairs at Princeton University, is helpful in differentiating between this model, its variations, and its counterparts. Cheng identified many examples of each model both abroad and within the U.S. While many might think of the single-payer model as socialized medicine, Cheng points out that a true system of socialized medicine exists when the government both funds and provides health care. A foreign example of this model is the inpatient sector of the British National Health Service, while the Veterans Administration is the manner in which socialized medicine has manifested itself in this country. Variation to a single-payer system, on the other hand, is created with the mixed delivery of health care services from government owned-facilities, private not-for-profit providers, and private for-profit health care providers. Both Canada and Taiwan have adopted these types of variable single-payer systems and, in the U.S., traditional fee-for-service Medicare as well as Medicaid are also examples of this model.

In the single-payer model's counterpart, the multiple-payer system, the government financing aspect remains and, in most cases, funding is based on payroll contributions or per capita premiums. Yet, a health insurance system consisting of multiple carriers that compete with each other for patients, also exist in these models. Cheng described a sub-set of this system, the all-payer system, in which countries such as Germany and Switzerland have regional associations of insurers that negotiate with providers for common fee schedules. In these countries, carriers are prohibited from earning profits from those covered by social insurance but can produce revenue through the sale of supplementary insurance. This system is mirrored by Medicare Advantage, or Medicare Part C, and Medicaid Managed Care. Finally, Cheng describes the easily recognizable private health insurance system of the U.S. pre-ACA, in which private insurers sell insurance to individuals or as employment-based group policies. As the ACA imposes additional government oversight, the individual mandate, and expanded social single-payer and multiple-payer initiatives, Cheng notes that there is truly no one U.S. health care model but simply "a pastiche of different systems."

What Can We Learn and How Can We Learn?

Cheng's testimony before the Senate subcommittee focused on the potential advantages of a single payer system. Specifically, she highlighted that such a system guards against financial ruined caused by medical bills as these systems are usually financed by taxes that are assessed based on an individual's ability to pay instead of an individual's health status. Cheng also pointed out that a patient in single-payer systems enjoys free range of choice when it comes to providers and because the "money follows the patients" providers are forced to compete not based on price but, rather, based on quality of services and patient satisfaction. Among the other notable points in Cheng's testimony of the advantages of a single payer system were that: (1) insurance is portable from job to job and through unemployment and retirement, (2) total health spending is easily controlled, and (3) the single payer system lends itself to a uniform electronic health information database that may be used to analyze and measure quality controls.

All of Cheng's testimony, however, was prefaced with the idea that single payer systems are ideal *if* "equity and social solidarity in access to health care and financing health care [are] fundamental goals of a health care system." In an interview with Wolters Kluwer, Cheng described three other specific factors that may constrain what can be transferred from one country to another in terms of health care models. First, Cheng noted that "the dominant theory of justice," that is, the ethical considerations that are embraced by individuals and must be reflected in a health care system, may play a part in limiting the applicability of certain models. She also noted that "path dependency of health systems," meaning the notion that "at any given time, a country's health system is the product of historical, cultural, legislative, and commercial developments of that country," also potentially constrains paths to change. Finally, Cheng noted that a country's system of governance, including the manner in which laws are passed and interests are represented is a major factor that limits what principles from other models may be adopted in a health care system.

In a similar vein, during the Senate subcommittee hearing, Victor Rodwin, MPH, Ph.D., Professor of Health Policy and Management at New York University, mentioned the following qualifier before describing the potential benefits that may be reaped with an analysis and adoption of certain aspects of the French health care system: "Health systems cannot be transplanted from one country to another, nor should they be. Looking abroad, at best, can inform policy debates at home." Rodwin went on to testify that three particular aspects of the French system translate into political values that many Americans embrace, namely liberalism, pluralism, and solidarity. Those aspects are as follows: (1) the free choice of providers, (2) the delivery of services by a variety of types of providers from private to nonprofit, and (3) the notion that those with greater wealth and better health finance the system to a greater extent than those with less wealth and poorer health. Rodwin also provided information in submitted written testimony that highlighted more specific characteristics of the French system, which Rodwin describes as "an example of public, social security and private health care financing, combined with a public-private mix in the provision of health care services." Specifically, reimbursement to providers according to nationally set rates, extensive co-insurance and voluntary health insurance, and the development of annual health care expenditure targets were noted by Rodwin to be among those principles that could "contribute to the discussion" of what may be learned from other health care systems.

In interviews with Wolters Kluwer, both Cheng and Rodwin provided further and more concrete examples of how exactly change could be or, more pointedly, is currently being integrated into the U.S. health care system. Interestingly, both experts pointed to initiatives in the U.S. in response to questions about what kind of changes could be enacted and how. Cheng described the all-payer system that has been adopted and operated for some time in the Maryland hospital system when asked what models would work well in the American context. To address the qualifiers that Cheng identified as political and structural obstacles for the adoption of a new system, she noted: "Maryland's all-payer system is something not totally alien to the rest of America. It is a home-grown system and anyone can easily visit to see and understand…"

Similarly, when asked whether the future of a strong health care system for the U.S. meant overturning the ACA, Rodwin responded that the current reforms in Vermont were informative. Rodwin did not advocate for the re-drafting of the ACA but for reconsideration as to how it is implemented. Specifically, Rodwin noted that "the ACA does not address the American problem of allowing too much choice of insurers and their health provider networks… there is too much emphasis [in the ACA, and in the U.S. more generally] on choice of insurer and not enough emphasis on choice of provider." He went on to assert that "it is a bad idea to be giving people too much of a choice of networks that keep changing and are difficult to understand for those not well versed in the details of health policy." In Vermont—where the governor signed a bill that will introduce a single-payer system within the state by 2017—Rodwin noted, people would not have to choose among different provider networks.

The specifics of the Maryland all-payer system and the potential adoption of a single-payer system in Vermont will be focused on in Part 2 of this Strategic Perspective. For now, Cheng's and Rodwin's comments are useful in thinking about whether change is possible in the U.S. system.

Is Change Possible?

The expert testimony at the Senate Subcommittee hearing provided brief overviews of the principles of other systems. Further analysis and interviews by Wolters Kluwer reviewed what principles of other models might be especially applicable to the U.S. system. The question of whether these policies will even be considered on a national scale, however, is highlighted by the dynamic exhibited on the floor of the Senate Subcommittee. When presented with the question of whether health care should be a universal right, one of the six experts on the panel answered that it should not and another answered that it was a universal right but should be free of government intervention. If these experts represent political opinion—and it should be noted that all three Republican senators that spoke in the hearing openly endorsed the work of the expert that did not endorse health care as a universal right—the answer to that question alone forecloses the consideration of any of the models discussed by Cheng and Rodwin as well as any other country's model that was mentioned in the hearing. With continuing debate over the fundamental question that must be answered in the affirmative before considering how exactly changes informed by other countries may be adopted, the chances of enacting such change seems slim.

Yet, the models adopted in certain domestic jurisdictions and referenced by both Cheng and Rodwin indicate that change is possible. Indeed, Rodwin argued, that "the fact that it is done in Vermont shows it's possible." While Cheng predicted that adoption of another type of health care system in the U.S. would not occur "because the supply side of U.S. health care is very powerful." She also stated that "increasingly, providers, payers and policy makers in the U.S. recognize the urgent need to make our health care system more efficient. I think there is shared recognition now that failure to achieve meaningful reforms will cost America as a country dearly." Rodwin further opined that change in regard to how the current system is to be implemented is "largely in the hands of the states." In that light, even if certain obstacles exist when considering other countries' models, perhaps the powerful forces of federalism that Chairman Sanders referenced in his opening remarks to the subcommittee could function to spread change from the small experiments in states and special sectors to the adoption of new national model over time.

Conclusion

While questions remain as to whether fundamental differences drawn along partisan lines will even allow for the consideration of other countries' health care models, the existence of other models within the American structure should be investigated. Part 2 of this Strategic Perspective will review both the Maryland hospital all payer system and the single payer system that is expected to be implemented in Vermont within the next few years. In addition, Part 2 will consider to what extent those models reflect the structure of health care administration of other countries and also what principles guiding those systems, both foreign and domestic, can be incorporated into the national structure of the health care system in the U.S. now that the ACA has been implemented.