

EDITORIAL

EJPH Policy Forum: risk adjustment strategies in three social health insurance countries

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It is not uncommon for national decision makers to find themselves wrestling Laocoon-like with inextricably contradictory health policy impulses. The effort to combine the economic efficiencies of competitive markets with the social responsibility of solidaristic health insurance can be viewed as one such instance.^{1,2} The complexity of this conceptual struggle in Social Health Insurance (SHI) systems is intensified by a desire to enable citizens to choose their health insurance provider, in the belief that this will increase the quality of care they receive from health care providers.

Attempts to resolve this prickly health policy conundrum typically have placed considerable emphasis on one or another relatively intricate mechanism of risk compensation. According to economic theory, such mechanisms can encourage both competitive behaviour among multiple health insurers and citizen choice of insurer without allowing the types of opportunistic behaviour (risk relation, selective disenrollment) that would jeopardize solidarity.³ These risk compensation mechanisms are often highly technical in nature and, as a consequence, discussions of their composition and character have tended to occur on the specialist periphery of the health reform debate. The central role that these mechanisms play, however, in the policy outcomes observed in SHI systems suggest that their composition should be more widely understood.

A variety of approaches to risk compensation are currently utilized in European SHI systems. The papers that follow present arrangements in place in three differently structured SHI health systems: Germany, The Netherlands, and Israel. Taken together, these papers suggest both the diversity of possible solutions as well as the complexity of the process required to initiate and maintain a reasonably appropriate risk compensation scheme.

A brief enumeration of differences in approach pursued among these three countries indicates a range of possible policy options. Israel adjusts its capitation payment only for age; Germany adjusts for age, sex, disability, and level of sick pay benefits; while Netherlands adjusts for age, sex, region, employment status, and disability. Both Israel and Netherlands collect funds in one central pot, and then

distribute a capitation payment to sickness funds on (at least formally) an individual and prospective basis. In Germany, each sickness fund collects its own revenues, with risk compensation arrangements that adjust for differential incomes as well as expenditures on a collective (fund-based) and retrospective basis. Interestingly, Dutch policymakers felt constrained to add several retrospective collective risk adjustment modifiers to their individual prospective formula in order to gain political acceptability, but hope to eliminate these 'temporary' modifiers in the unspecified future. German policymakers continue to express hope that the entire (collective retrospective) risk adjustment exercise can be discontinued, again in the unspecified future. Policymakers in all three countries continue to explore the parameters utilized in their risk adjustment formulas, with consistent interest in incorporating health status and/or morbidity as a variable in the future.

Each of these differences raises a number of important research questions for future study. Are more complex formulas more equitable than simpler ones? Do retrospective/collective approaches work better than individual/prospective ones? How tightly must the state regulate the overall practices of health insurers (statutory and non-statutory) in order to create a protected environment within which risk adjustment formulas can function effectively? These and other questions are of interest to policymakers in countries that seek to construct socially responsible SHI systems – in particular the countries of Central and Eastern Europe. Such topics may also become of interest in the USA, given the slow collapse of its existing managed competition arrangements.

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