

Influence of health insurance providers on medical practice and patient experience

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Abstract

This study analyzes the influence of health insurance providers on medical practice and patient experience in Brazil, the United States, and Europe. It discusses reimbursement models, clinical autonomy, access to care, user satisfaction, and cost-effectiveness. The results indicate that different contractual and regulatory arrangements shape the physician-patient relationship and equity in access to services. The financial sustainability of healthcare systems must be reconciled with the bioethical principles of autonomy, beneficence, non-maleficence, and justice. The analysis highlights the need for medical practices and management policies that ensure quality, transparency, and patient-centered care.

Keywords: Bioethics. Patient satisfaction. Health systems. Health judicialization. Health management.

Resumo

Influência das operadoras de saúde na prática médica e na experiência do paciente

O estudo analisa a influência das operadoras de planos de saúde na prática médica e na experiência do paciente no Brasil, nos Estados Unidos e na Europa. São discutidos modelos de remuneração, autonomia clínica, acesso a cuidado, satisfação dos usuários e custo-efetividade. Os resultados indicam que diferentes arranjos contratuais e regulatórios moldam a relação médico-paciente e a equidade no acesso a serviços. A sustentabilidade financeira dos sistemas de saúde deve ser conciliada com os princípios bioéticos da autonomia, beneficência, não maleficência e justiça. A análise evidencia a necessidade de práticas médicas e políticas de gestão que assegurem qualidade, transparência e centralidade no paciente.

Palavras-chave: Bioética. Satisfação do paciente. Sistemas de saúde. Judicialização da saúde. Gestão em saúde.

Resumen

Influencia de las aseguradoras de salud en la práctica médica y en la experiencia del paciente

El estudio analiza la influencia de las aseguradoras de salud en la práctica médica y en la experiencia del paciente en Brasil, Estados Unidos y Europa. Se discuten modelos de remuneración, autonomía clínica, acceso a la atención, satisfacción de los usuarios y costo-efectividad. Los resultados indican que diferentes arreglos contractuales y regulatorios moldean la relación médico-paciente y la equidad en el acceso a los servicios. La sostenibilidad financiera de los sistemas de salud debe conciliarse con los principios bioéticos de autonomía, beneficencia, no maleficencia y justicia. El análisis evidencia la necesidad de prácticas médicas y políticas de gestión que aseguren calidad, transparencia y centralidad en el paciente.

Palabras clave: Bioética. Satisfacción del paciente. Sistemas de salud. Judicialización de la salud. Gestión en salud.

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The expansion of health insurance providers has led to significant transformations in contemporary medicine organization and practice. These intermediary agents have played a growing role in regulating the relationship between physicians, patients, and financing systems, influencing clinical decision-making and the very concept of care. In Brazil, the coexistence of the Brazilian Unified Health System (SUS) and the private sector underscores a tension between the universal right to health and market mechanisms that condition access and professional autonomy¹.

The United States and Europe experience an equally complex context, with financing models that vary between the predominance of private insurance and universal public systems. Studies demonstrate that different payment arrangements, such as fee-for-service (FFS), capitation, and pay-for-performance (P4P), strongly inform physician behavior and healthcare resource utilization^{2,3}. These mechanisms can both encourage efficient practices and generate ethical distortions, such as overuse or underutilization of procedures.

Despite the relevance of the issue, comparative studies with integrated analysis of the bioethical and clinical effects of the operation of health insurance companies on different systems are still scarce. Most studies focus on economic and managerial aspects, neglecting dimensions such as clinical autonomy, equity, and user satisfaction⁴.

This gap justifies this study, whose general objective is to analyze the influence of health insurance providers on medical practice and patient experience, considering comparative perspectives among Brazil, the United States, and Europe. Specifically, the aim is to discuss how different payment, governance, and regulation models affect clinical autonomy, access to care, quality of care, and the bioethical principles that guide contemporary medicine.

Method

This is a systematic literature review, following the recommendations of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses checklist (PRISMA). The review was based on the research problem and analytical objectives according to the need to understand how

different health system financing, regulation, and organization models affect clinical decision-making, professional autonomy, access to care, quality of care, and user perception.

The bibliographic search was conducted in recognizedly relevant international scientific databases, including PubMed, Scopus, and Web of Science, complemented by grey literature and institutional documents from regulatory agencies and international organizations, such as the National Regulatory Agency for Private Health Insurance and Plans (ANS), the National Health Service (NHS), and the Centers for Medicare & Medicaid Services.

Controlled descriptors and keywords were combined using Boolean operators, including terms such as “health insurance,” “managed care,” “physician behavior,” “medical autonomy,” “patient experience,” “health systems,” “payment models,” “fee-for-service,” “capitation,” “pay-for-performance,” and “health economics,” with search strategies adapted to the specificities of each database⁵.

Studies published between 2005 and 2025, in Portuguese, English, and Spanish, addressing the influence of health insurance companies or providers on medical practice, professional behavior, access to services, patient experience, or economic evaluation in health were included. Empirical studies, systematic reviews, and comparative analyses with a relevant contribution to the proposed objectives were considered eligible. Works without peer review, studies with an exclusively clinical focus without interface with the organization of health systems, publications without relevant data or analyses, and duplicate records identified among the databases were excluded⁶.

The study selection process followed the steps recommended by PRISMA, starting with the identification of records in the databases, followed by removal of duplicates, screening by reading of titles and abstracts, and evaluation of full texts as to previously defined eligibility criteria. Afterwards, the studies considered relevant were included in the qualitative analysis. Selection process was systematized in a diagram according to PRISMA guidelines, seeking methodological transparency and reproducibility.

The study adopted as theoretical framework the concepts of health governance⁷, health economics⁸, patient-centered care⁹, and health technology assessment⁸, which enabled a multidimensional and integrative approach to the studied phenomena. This methodology provided systematic insights into how structural, financial, and organizational factors influence medical practice, patient experience, and health system outcomes.

Results and discussion

The scientific literature on health systems and the operation of health plan and insurance providers still presents significant gaps when seeking insights into contextual differences between countries. In Brazil, studies focus primarily on the tension between supplementary health and the SUS, emphasizing issues with regulation and inequalities in access, but lack international comparative analyses that provide insights into the limits and potential of this model¹.

In the United States, the literature is extensive regarding the role of private insurers and the impact of the fragmented system on equitable access. However, several studies do not dialogue in depth with the experiences of developing countries, such as Brazil, limiting knowledge transfer and the construction of more comprehensive evaluation parameters¹⁰.

In Europe, there is a consolidated tradition of comparative studies on universal and mixed health systems, especially as to the balance between public and private funding. However, few studies provide a comparative perspective that includes Latin America, which makes it difficult to understand how different regulatory arrangements can impact patients and professionals in diverse socioeconomic contexts¹¹.

Thus, this comparative review including Brazil, the United States, and European countries contributes toward identifying convergences and divergences in regulatory models, the role of providers, and the effects on medical practice and patient experience, supporting academic debate and providing inputs for more evidence-based public policies⁴.

The contractual and payment models for health services vary according to the regional historical, economic, and regulatory context. The fee-for-service model, based on payment per procedure, is traditional in the United States, being associated with the expansion of service supply, but also criticized for encouraging excessive consumption and increasing costs in healthcare¹².

The capitated payment model, in which providers receive a fixed amount per patient over a given period, is more widespread in countries with regulated systems and a focus on primary care, such as the United Kingdom and some European countries. This form of payment encourages the rationalization of resources and continuous patient monitoring, but can generate risks of under-supply of services when there are no adequate monitoring mechanisms³.

Bundled payments, characterized by a single payment per episode of care that covers all related services, have been implemented on a pilot basis in systems such as the American and European systems. This model seeks to align efficiency and quality by promoting greater coordination between teams and avoiding care fragmentation¹³.

Finally, pay-for-performance has received international relevance, with financial incentives based on quality and clinical outcome indicators. Germany and the United Kingdom use P4P in programs focused on primary care; in the United States, the model is practiced in hospitals and clinics associated with government initiatives such as the Medicare Value-Based Purchasing Program².

In Brazil, there is a predominance of fee-for-service in the supplementary sector, even though experiments with capitation and P4P are being tested by some health insurance providers. The heterogeneity of these models reflects the influence of cultural, regulatory, and financial factors, making a comparative analysis between regions essential to understand their effects on costs, quality, and access to healthcare¹⁴.

Economic and organizational incentives significantly inform physician behavior, influencing decision-making related to prescription of medications, referral to specialists, and the use of complementary tests. In fee-for-service systems, the payment logic encourages a higher volume of procedures, which can result in excessive diagnostic

tests and unnecessary treatments, increasing costs and exposing patients to additional risks¹⁵.

On the other hand, capitated payment models, in which physicians or institutions receive a fixed amount per patient, encourage cost containment and care rationalization. This configuration can lead to a reduction in referrals and tests considered as of low value; however, it also raises concerns about the risk of underuse of resources and detriment to the quality of care³.

P4P programs seek to align financial incentives to quality of care, rewarding evidence-based practices such as rational drug prescription and adequate management of chronic diseases. However, the literature indicates that such initiatives can induce strategic behavior, focusing only on monitored indicators, neglecting relevant but unevaluated dimensions of clinical practice².

Additionally, factors that are not only economic but also cultural and institutional influence physician behavior. In Brazil, for example, studies show that both patient pressure for tests and the influence of health insurance providers in the authorization of procedures directly interfere with medical decision-making, creating tensions between professional autonomy, financial sustainability, and quality of care¹.

Understanding the effects of different incentives on prescription, referral, and the use of tests is essential for building contractual models that reconcile economic efficiency with quality and safety in healthcare. Critical analysis of these mechanisms contributes toward identifying strategies that avoid both overuse and underuse of medical services, ensuring greater balance between the interests of providers, funders, and patients⁴.

The clinical autonomy of healthcare professionals is a central issue in discussions about the quality and sustainability of health systems. The advancement of clinical protocols, therapeutic guidelines, and monitoring mechanisms seeks to ensure standardization of conducts and greater patient safety. However, this process also generates tensions, as it can be perceived as a limitation to professional freedom and to the individual judgment of each case¹⁶.

Clinical protocols and guidelines are important instruments for rationalizing care, contributing toward reducing unjustified variations in medical practices. Studies show that adherence to guidelines improves treatment effectiveness and reduces risks associated with overuse or misuse of resources. However, there are criticisms as to the risk of turning recommendations into rigid rules, that disregard patient specificities and physician experience¹⁷.

The monitoring of medical practices through audits and computerized tracking systems has become increasingly frequent in both private and public supplementary healthcare systems. This monitoring can promote transparency and accountability, in addition to reducing waste. However, it can affect professional relationships, leading physicians to feel pressured by administrative metrics, to the detriment of their clinical autonomy¹⁸.

In Brazil, the relationship between health insurance providers and physicians exemplifies these tensions. While protocols and audits seek to align conducts with quality and cost containment standards, several professionals perceive such instruments as corporate control mechanisms that weaken autonomy in medical practice. This situation influences not only professional satisfaction but also the quality of the physician-patient relationship, as clinical decisions can be conditioned by external factors¹⁹.

The challenge lies in balancing the use of protocols, guidelines, and monitoring as tools for quality improvement, without compromising professional autonomy and the uniqueness of clinical practice. The construction of participatory models, which involve physicians in the development and review of guidelines, proves fundamental for reconciling efficiency, safety, and autonomy in healthcare⁴.

Access to and continuity of care are fundamental elements for ensuring the comprehensiveness of healthcare, especially in systems that combine public and supplementary coverage. The referenced network of health insurance providers, for example, functions as an access filter, defining which services and professionals are available to users. This model can facilitate the coordination of care, but it also generates inequalities when the supply is restricted

or when there is a concentration of providers in certain regions¹.

Waiting lists constitute another challenge for the continuity of care, especially in countries with universal systems, such as those in Europe. The delay for specialized consultations and elective procedures can compromise therapeutic effectiveness and patient satisfaction. Studies show that waiting time is directly related to resource scarcity and the organization of the healthcare network, demanding policies that reconcile efficiency and equity²⁰.

The gatekeeping mechanism, in which general practitioners act as a mandatory entry point to the system, is widely adopted in Europe and parts of the United States. This model seeks to organize healthcare flows, reduce unnecessary referrals, and strengthen primary health care. However, critics point out that, in some contexts, gatekeeping can turn into a barrier to access, limiting patient autonomy and delaying access to specialized services²¹.

In Brazil, the gatekeeping logic is still not well consolidated in supplementary healthcare, with predominance of direct access to specialists which can lead to fragmentation of healthcare and overuse of tests. In the SUS, the attempt to strengthen primary health care as the entry point faces structural and funding obstacles. Thus, the balance between timely access and continuity of care remains a central challenge for different healthcare models¹⁴.

Patient satisfaction and experience have become central dimensions in the assessment of healthcare service quality, complementing traditional indicators such as clinical effectiveness and economic efficiency. These aspects reflect the user perception of the service received, including factors such as physician-patient communication, waiting time, accessibility, and involvement in care decision-making²².

In the United States, standardized instruments such as the Consumer Assessment of Healthcare Providers and Systems are widely used to measure patient experience. The results of these surveys are applied in transparency policies, comparisons between providers, and even in pay-for-performance programs, reinforcing the accountability of healthcare institutions²³.

The United Kingdom and the Netherlands have a long tradition of monitoring patient experience via national surveys, such as the NHS Patient Survey Programme. The obtained data enable regional and international comparisons, in addition to supporting policies geared toward continuous improvement of care, especially in strengthening primary health care⁹.

In Brazil, although studies on user satisfaction are increasingly frequent, systematic evaluation is still incipient, especially in supplementary healthcare. Studies indicate that the main factors of dissatisfaction are related to delays in access, provider bureaucracy, and insufficient communication with healthcare professionals, underscoring the need for standardized instruments to consistently measure and compare experiences²⁴.

Conflicts of interest in the healthcare sector primarily arise from financial intermediation between healthcare insurance providers, service providers, and patients. The influence of economic incentives, commercial contracts, and corporate relationships can compromise professional autonomy and equity in access to services, making governance a central aspect to ensure the integrity of the system²⁵.

Transparency is one of the pillars of good governance, as it provides patients, managers, and regulators with insights into the financial flows and institutional relationships that permeate medical practice. International experiences show that the disclosure of payments from the pharmaceutical industry to physicians, as occurs in the United States' Open Payments program, strengthens accountability and helps prevent unethical conduct²⁶.

In the European context, oversight mechanisms seek to balance the interests of different actors of the healthcare system via independent regulatory organs and systematic audits. Moreover, corporate governance initiatives have been consolidated as a means to reduce information asymmetries and prevent practices that could affect public trust in healthcare systems⁷.

In Brazil, the ANS plays a strategic role in the regulation of the sector, establishing rules for transparency, monitoring of health insurance and plan providers, and protection of consumers. Despite

the advances, there are still challenges related to effective oversight, information asymmetry between users and providers, and the need for greater social participation in system governance¹.

Strengthening governance in healthcare requires the implementation of robust mechanisms for transparency, auditing, and oversight, in addition to building an institutional culture that prioritizes ethics and accountability. Such measures are essential to minimize conflicts of interest and promote fairer and more sustainable health systems⁴.

Healthcare outcome assessment and cost-effectiveness analysis are essential for guiding clinical, managerial, and public policy decision-making. Measuring clinical outcomes, quality of life, and economic impact enables the comparison of interventions, prioritization of resources, and improvement of allocation in healthcare systems with limited resources⁸.

In the United States and Europe, cost-effectiveness analysis is consolidated in health technology assessment organizations, such as the National Institute for Health and Care Excellence (NICE) in the United Kingdom, which uses rigorous criteria to recommend treatments based on clinical and economic evidence. These studies include analysis of cost per quality-adjusted life year (QALY) and enable comparison between different therapeutic strategies²⁷.

In Brazil, the incorporation of technologies and medicines into the SUS also requires cost-effectiveness analysis, conducted by the Department of Health Economics and Health Technology Assessment (DEATS/CONITEC). Although data are still limited in some contexts, Brazilian studies show that economic analyses can optimize resource allocation and support financing decision-making in supplementary and public healthcare²⁸.

In addition to economic aspects, healthcare outcomes encompass quality, safety, and patient experience indicators. The integration of these parameters with cost-effectiveness analyses provides more balanced decisions, that consider both efficiency and equity in healthcare⁴.

Therefore, systematic healthcare outcome measurement and cost-effectiveness analysis are strategic tools for healthcare planning and management, contributing toward more sustainable and evidence-based healthcare systems.

The comparison between the healthcare systems of Brazil, the United States, and European countries shows structural, regulatory, and financing differences with direct impact on medical practice and patient experience. In Brazil, the SUS, coexists with the supplementary healthcare sector, composed of private health plan providers, seeking to ensure broad coverage but facing challenges such as regional inequality, financial restrictions, and limited management of access and continuity of care¹⁴.

In the United States a predominance of a fragmented private health system is observed, based on health insurance and fee-for-service. The model provides quick access and advanced technology, but with high costs, unequal coverage, and regulatory complexity. Financial incentives have a strong influence on medical practice, affecting prescriptions, referrals, and the use of tests, with less coordination between healthcare levels¹⁰.

In Europe, there is a predominance of universal and regulated systems, with public or mixed funding, varying from country to country. Models such as the British (NHS) or the Dutch emphasize structured primary health care, gatekeeping, and cost control policies. These systems combine capitated payment mechanisms and performance-based quality programs, seeking a balance between efficiency, quality, and equity¹¹.

In terms of patient satisfaction and experience indicators, comparative studies indicate that European countries and the United Kingdom show consistent results due to standardized metrics and systematic monitoring, while in Brazil there are challenges related to the heterogeneity of assessment tools and unequal access to supplementary and public healthcare services. In the US, measures such as the CAHPS assist in monitoring, but system fragmentation limits information integration²².

Finally, regarding healthcare outcomes and cost-effectiveness, European and American systems have a consolidated tradition in the economic evaluation of technologies and treatments. In Brazil, this process is developing, with regulatory requirements for incorporation of technologies and medicines; however, there are still gaps in the availability of comparative data and in the large-scale application of cost-effectiveness analyses^{4,28}.

The analysis of different aspects of supplementary healthcare and health systems showed important patterns concerning the influence of health insurance providers, payment models, and governance policies on medical practice and patient experience. It was observed that the operation of health insurance providers directly impact clinical decision-making, including prescriptions, referrals, and the use of tests; such influence is particularly significant in fee-for-service contexts, which are predominant in the United States, and, to a lesser extent, in capitated and performance-based models, which are more common in Europe^{3,15}.

As far as clinical autonomy is concerned, protocols, guidelines, and monitoring have a dual effect: on the one hand, they contribute toward the standardization of conduct and patient safety; on the other hand, they can restrict clinical judgment and create tensions in professional relationships, especially in systems in which health insurance providers have intense administrative control, as observed in the Brazilian supplementary healthcare sector^{4,16}.

Access to and continuity of care showed significant differences between regions. The gatekeeping logic and structured primary health care in Europe favors coordination and continuity, while the fragmented US system and direct access to specialists in Brazil present

challenges as to integration, waiting time, and equity in healthcare^{14,21}.

The patient satisfaction and experience assessment showed that standardized instruments, such as the CAHPS in the US and national surveys in Europe, provide robust data for quality improvement, while in Brazil the heterogeneity of metrics limits systematic monitoring and comparisons^{1,22}.

The healthcare outcome and cost-effectiveness analysis, when available, demonstrated that European and American systems have a consolidated application of economic evaluation methods, while in Brazil there is an increasing adoption of this type of analysis, mainly for technology incorporation into the SUS and private plans, although still with gaps in comparative data^{8,28}.

The results indicate that payment models, governance mechanisms, transparency policies, access management, and patient experience focus are interdependent. In combination, these factors have a direct influence on efficiency, quality, and equity in healthcare systems, which underscores the importance of international comparative analyses to support improvements in medical practices and public policies.

Chart 1. Comparison between health systems and their impacts on medical practice and patient experience

Dimension analyzed	Brazil	United States	Europe
Health system model	Universal public system (SUS) coexisting with the private supplementary sector	Predominantly private and fragmented system	Universal or mixed systems with strong state regulation
Predominant payment model	Predominance of FFS in supplementary healthcare, with emerging experiments with capitation and P4P	Predominance of FFS, with expansion of value-based models	Combination of capitation, global budgeting, and P4P
Influence of health insurance providers on medical practice	High influence in the authorization of procedures and control of costs	Strong influence of insurers on clinical decision-making and care organization	Regulated influence, with greater state and institutional mediation
Medical autonomy	Partially limited by protocols and audits of insurers	Conditioned by financial incentives and contracts with insurers	More balanced, with institutionalized clinical guidelines and professional participation

continues...

Chart 1. Continuation

Dimension analyzed	Brazil	United States	Europe
Access to care	Uneven, with regional differences and segmentation between the SUS and the private sector	Quick access for policyholders, but unequal depending on coverage	More equitable, with organization through primary health care and gatekeeping
Continuity of care	Fragmented, especially in supplementary healthcare	Low coordination between care levels	High coordination, with strong integration of primary health care
Patient experience	Still incipient and heterogeneous assessment	Use of standardized instruments (CAHPS), but fragmented system	Systematic and standardized monitoring of patient experience
Cost-effectiveness analysis and economic evaluation	Expanding, especially in the SUS	Widely used, with strong influence on health policies	Consolidated, with institutions such as NICE guiding decision-making
Main challenges	Inequality in access, fragmentation, and insufficient regulation	High cost, inequality, and fragmentation	Financial sustainability and waiting list management

Final considerations

The above analysis shows that the operation of health insurance providers goes beyond organizational and economic dimensions, constituting an ethical phenomenon with direct impacts on medical practice and patient experience. Payment models, regulatory mechanisms, and care control devices influence clinical decision-making, conditioning professional autonomy and redefining the physician-patient relationship.

In light of principlism, there are tensions between autonomy, beneficence, non-maleficence, and justice, above all when financial incentives favor the overuse or underutilization of procedures. In the field of justice, there are still inequalities in access, associated with segmentation between

systems and barriers imposed by health insurers, compromising equity in healthcare.

From a broader ethical perspective, medical practice should be understood as a moral activity oriented towards patient well-being, which comes into tension with managerial rationalities focused on efficiency and cost control. In this sense, the sustainability of health systems require a reconciliation between economic viability and ethical responsibility, in order to preserve the quality of care and the dignity of the individuals involved.

In conclusion, the healthcare-related institutional and financial arrangements are not ethically neutral, being fundamental the incorporation of bioethical frameworks into the formulation of policies and the organization of medical practice. Such integration is essential to promote more equitable, sustainable, and patient-centered health systems.

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Rui Nunes: conceptualization; supervision; writing - review & editing.

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