

The Swiss Healthcare System (2002)

Characterised by liberalism and federalism, Switzerland has an extremely well developed healthcare system.¹ The liberal element restricts state activity to guaranteeing health care ‘when private initiative fails to produce satisfactory results’.² As a Confederation, the national authorities can only legislate when empowered so to do by constitution.³ This includes only the guaranteeing of social insurance, the regulation of medical examinations and qualifications, and certain public health activities.

“There is a mantra in Swiss healthcare politics, a phrase one hears again and again: healthcare in Switzerland is of excellent quality, [but] quite expensive”.⁴ Indeed, according to OECD statistics, Switzerland operates the third most expensive system in the world – behind only the USA and Germany. Though if calculated in US \$ PPP, Switzerland easily outspends all countries in the European region. So does spending more ensure better health care? It can, yes, but there are at least **four other notable features** to learn from in the Swiss health care system:

Preferences of (potential) patients determine the structure of the system to a degree found in few other countries. The population of just over 7 million, divided between four language communities (French, German, Italian and Romansch), is directly involved in a three-level political process, through seemingly-continual referenda. This means that patients really do influence the system – voting on local hospital enlargements for example.⁵ As a prosperous and modern economy with a GDP per capita 15%-20% above that of the big West European economies,⁶ the demanding Swiss who expect to remain in an optimal state of health until death choose to spend a lot (approaching 11%GDP) on health care. There is no governmental cap on total expenditure.

Decentralization of political power is marked in the Swiss Confederation, with the 23 cantons, three of which are split into demi-cantons, acting autonomously in the organisation of healthcare in their area – specifically cantons are charged with regulation, hospital accreditation and finance along with disease prevention and health education.⁷ The result is 26 slightly different systems.⁸ Local supervision of healthcare is the responsibility of cantonal health ministers. That said, the cantons operate within a federal framework. For example, the constitution allows all insurers and service providers to operate throughout the Confederation. This framework provides the opportunity to learn from the successes and failures of other cantons. The 3000+ local authorities implement certain responsibilities conferred upon them (e.g. nursing and home care management, referred to as ‘*Spitex*’ services), by the cantons.

A High Degree of Competition: The new Law on Health Insurance of 1994 (in force from 1 Jan. 1996, having survived a popular referendum) injects a degree of competition into the health care system that is certainly comparable to the Netherlands.⁹ In theory there are three markets. Both insurers and providers compete for patients as customers (in effect this is an extension of our first characteristic, preferences of patients). Insurers may also selectively contract with primary care providers.

Unusual Public/Private mix: Swiss healthcare insurance combines public, subsidised private and fully private healthcare in a unique manner.¹⁰ Like most developed countries, the Swiss healthcare system is funded through combination of public and private sources. However, the proportion of expenditure from public sources is one of the lowest in the European region.¹¹ Healthcare expenditure structure has also changed markedly over the past 20 years. Specifically:

- Tax financing has decreased since 1980 from 31.7 % of total expenditure to 24.9% in 1997.
- Health insurance financing (the sum of compulsory and not for profit supplementary health insurance) has increased since 1980 from 33.4 % of total expenditure to 37.5% (27.5 +10.0) in 1997.
- Direct payments (the sum of cost sharing in the compulsory health insurance and for profit supplementary health insurance) have decreased since 1980 from 32.4 % of total expenditure to 28.8 % (27.6 +1.2) in 1997.

The World Health Organisation (WHO) determines that the funding structure differs according to whether one looks at those bodies making payments or those bearing costs.¹² WHO notes that in 1997, health insurers assumed the main share of direct cost reimbursement (48%), followed by private households (e.g. through co-payments) (24%), cantons and local authorities (together 15%), and old age / disability and accident insurance (10% in total). However, if funding structure is divided up according to those actually bearing the costs, private households occupy first position (65%) followed by cantons (15%), the federal government and business (7% each), and local authorities (under 3%).¹³

Bearing in mind these four characteristics, we now look at how Swiss health care is paid for, organised and provided.

HEALTH INSURANCE

The Swiss health insurance system has three components: compulsory basic social insurance; voluntary supplementary insurance; and sickness, old-age and disability insurance. We will look at these in turn.

Compulsory Basic Social Insurance (CBSI):

Having been given the mandate to legislate on sickness and accident insurance in 1890, the first Swiss health insurance law was passed by the Federal Government in 1911. It required insurers to register with the Federal Office for Social Insurance, and to offer a statutory package of benefits. The insured had some freedom to change fund, premiums were regulated, and funds were not allowed to make a profit. Unlike social insurance in France and Germany, the 1911 law stated that insurance should be individually contracted not employer based. The cantons could decide whether the insurance was compulsory, and by 1990, nearly 98% of the population purchased this insurance.¹⁴

Owing to serious and persistent financial difficulties of sickness funds, several attempts were made to radically reform the law throughout the 20th century, but these failed in referenda. From 1958 more incremental reforms were muted (revisions of the subsidy system and the introduction of compulsory user charges) which, following partial reforms of 1964 put health insurers on a better financial footing. Expenditure continued to rise quickly in the 1970s and 1980s, but attempts at reform failed. It was not until the Revised Health Insurance Law of 1994, that a major reform was enacted.¹⁵ The new law, which made significant changes to the system of subsidies, promised compulsory comprehensive healthcare at an affordable cost. It expanded the benefits package, aiming to increase efficiency rather than restrict the extent or quality of benefits¹⁶ In contrast to employment-based healthcare in the US, where the poor can receive a demonstrably lower standard of care, the Swiss hoped to enable universal care based on freedom of choice with guarantees for the poor. Hence, the new Swiss system would embrace voice and exit for the whole population.

Since the Revised Health Insurance Law came into force in January 1996, all Swiss residents must have basic health insurance. This is mandatory in order to satisfy objectives of collective responsibility.¹⁷ Insurers, which under the Health Insurance Law must register with and are monitored by the Federal Social Insurance Office (itself subordinate to the Federal Department of the Interior), are obliged to accept all applicants, thereby avoiding cream-skimming. The insured may change insurer twice per year.

Choice of Insurer: Both registered health insurance funds and private insurers are permitted to provide the compulsory basic insurance. There are 93 registered insurance funds offering compulsory basic insurance in 2002. In 1993 there were 207, in 1977, there were 615, in 1945, 1,151. There doubtless will be further insurer mergers. These companies, whose membership varies in size in 2000 from 256 (Krankenkasse Unitas, Binn), to 1,129,479 (Helsana Versicherung, Zurich), may be federal, regional (e.g. KK der Region, Goms), religious (e.g. Christlich-Soziale de Schweiz Versicherung) or occupationally based (e.g. Betriebskrankenkasse der Chocoladefabriken Lindt + Sprungli).^{18, 19, 20} All are run on a not-for-profit basis though under the new CBSI law this is no longer a requirement.²¹ Insurers group together in Cantonal and Federal Associations to negotiate fees with service providers, represent the interests of members, compile statistics and so forth.²² This long-standing group negotiation is likened by many to a cartel.²³

Basic Benefits Package: ‘Basic’ is a real misnomer here as it implies that significant elements of healthcare must be purchased in addition. This is not the case, indeed Zweifel among others likens the Swiss ‘basic’ package to a luxury one in the US or Germany.²⁴ The health insurance law defines the scope of the benefits package under compulsory insurance. Benefits are standardised throughout the federation. The package which covers the cost of medical treatment in the canton of residency, includes inpatient and outpatient care, care for the elderly and physically and mentally handicapped, unlimited stays in nursing homes and hospitals, diagnosis, and so forth. Since 1999, alternative and complementary medicine benefits are also included.²⁵ Services covered must meet criteria of clinical effectiveness, appropriateness and cost-effectiveness. However, these tests have only been applied to potential additions to the package, not those already included.²⁶

In order to fulfil their obligation to pay for care by providers of the patient’s choice, the new law subjects health insurers to an ‘any willing provider’ (AWP) clause, albeit with expectations for managed care.²⁷ This means that selective contracting has been possible since the 1994 law. However, it is not much used; Zweifel suggests that insurers are more concerned with setting the correct (uniform) premium than with reducing the cost of care purchased through selective contracting.²⁸ Regarding hospital contracting, insurers are subject to an AWP clause applicable to all canton-accredited hospitals.

As there is a statutory package, companies are not allowed to compete on the basis of benefits package. Goddard and Jacobs consider that there is also little scope for competition based on quality of service.²⁹ Instead, insurers compete on the basis of price – that is premiums and variable deductibles. Traditionally the Swiss stayed with one fund for life. Insurers now spend a lot on marketing and advertising, and switching between insurers is more common.

Premiums: Swiss premiums, which are federally regulated but not fixed, are independent of income. They are community rated, that is, the same for every person taking out a policy with a given company in a given area, regardless of individual risk rating. Premiums, which vary from insurer to insurer, may vary by 50% from canton to canton, and are payable directly to the insurer on a monthly basis. The insured shop around for best premium rates. Prior to 1996, premiums were risk-related, thus some with high risk found health insurance unaffordable.³⁰ The cost of insurance is now roughly £1500 per person annually.³¹ Patients may also opt for bonus options for no claims (as in the German private insurance market).

Every family member is insured individually, regardless of age.³² Thus, spouses and children must also be separately enrolled as cover is not automatic. Parents have 3 months to insure new-born children.³³ All insurers offer very much lower premiums for children, adolescents, and young adults in training/ education (up to age 25).³⁴ But what about those who cannot pay?

Premium Subsidies: The Health Insurance Law states that premiums for the less well off and certain families must be reduced. Thus, means-tested tax-financed subsidies from the state and cantons are paid directly to the insured whose premiums comprise more than 8-10% of income. In 1998 roughly 30% of the insured benefited from such reductions – a percentage which varies significantly between the cantons which have autonomy to define the principles on which premium subsidies are based.³⁵ However, subsidies do not bridge the gap fully between gross premiums and the commonly set subsidy threshold; as to do so would encourage subsidised individuals to opt for the most expensive plans with the lowest possible deductible (see below).³⁶

Patient Co-payments: There are co-payments in the form of an annual minimum deductible or “*franchise*”: this payment starts from a minimum of SwF. 230, called *franchise ordinaire* (FO), and insurance companies can offer deductibles up to SwF. 1500 (max). The insured can reduce their premium by opting for one of these higher deductibles - called *franchises a option* (FAO). In order to protect solidarity, premium reduction limits are set annually by the federal government. A policy with a *franchise* of SwF 230 is subject to no premium reduction. A FAO of SwF 400 results in a premium reduction of up to 8%. One of SwF. 600 results in a premium reduction of up to 15%. FAO SwF1200 can reduce premiums by 30%, while the maximum FAO of SwF. 1500 can lead to a premium reduction of 40%.

There is also an excess charge of 10% up to a maximum of SwF 600 per year for all ambulatory medical costs over and above the “*franchise*”. During in-patient care those from single-occupant households must pay hotel-type expenses of SwF.10 per day. Certain co-payment exemptions apply for children.

More choice for Patients through New Healthcare Solutions: The Revised Health Insurance Law leaves room for innovative funding and provision solutions. In this context, managed care organisations have been established, offering restricted choice in return for lower premiums. Two forms of managed care have developed so far. Patients may opt for an HMO-type policy, or may choose to join the ‘General Practitioner network system’. The new law leaves the door open to other solutions which may be created in the future.³⁷

HMOs: ‘The leading social health insurers now all have HMO divisions. The first HMO group practice opened its doors in Zurich in 1990, followed by another in Basel in 1991.’³⁸ By 1997 there were fewer than 10 HMOs - with a market share of less than 3% (rapidly increasing). At the time they were ‘staff-model HMOs, employing salaried physicians’.³⁹ HMOs are mostly insurance-owned group practices in which the doctors are employed on a salary basis. There are two doctor-owned HMOs.⁴⁰ In 2002, premiums for HMO policies are 10-20% lower than those for the standard FO policies.

GP Physician networks: In many ‘smaller cities, primary care networks were created, comprising mainly GPs who agreed to act as gatekeepers for participating insurers.’ Network physicians seek to prevent unnecessary hospitalisations: as a group (in 1997) they share 50% of the profits and losses of the plan, with a cap in the event of loss, of SwF.10,000 per physician per year.⁴¹ In 2002, premiums for GP Physician Network policies are roughly 5-15% lower than those for the FO policies.

While both of these forms of managed care can reduce hospitalisation rates, unlike US HMOs they cannot negotiate on price with hospitals by establishing preferred provider contracts. Managers of public hospitals are prevented from creating such contracts in return for lower fees, as the authority to do so rests with cantonal parliaments, as they are so ‘heavily engaged in the financing of “their” hospitals’.⁴² The Revised Health Insurance Law specifies that cantons must cover 50% of hospital costs, and requests that cantons draw up lists of hospitals with which insurers must contract. Thus hospital sector competition is stifled.⁴³

Risk Adjustment: In 1996, the registered insurance companies created 'Foundation 18' – a solidarity body responsible for risk adjustment in light of differential risk pool problems. The formula is based on age and sex of the insured. Some, particularly insurers, suggest this ought to be changed to include other criteria such as the number of hospital treatments per year.⁴⁴

Tax Finance.

Adding to the complexity of the Swiss system, federal, cantonal and local authority tax revenues constitute another source of healthcare finance – amounting to 24.9% of total expenditure in 1997. This tax revenue covers: cantonal subsidies to both private and public hospitals; cantonal and municipal subsidies to nursing homes and homecare providers; cantonal and federal subsidies for compulsory health insurance premiums; cantonal and federal public health expenditure.⁴⁵

Supplementary Insurance.

Supplementary insurance financed 11.2 % of total health care in 1997. In 1998, almost two-thirds of the registered insurance companies offering CBSI (63) also offered voluntary supplementary insurance. In addition, 61 non-registered (ie for-profit) insurance companies offered supplementary insurance. Cover is available for treatments not covered by the basic package (e.g. for some dental care) or (as in France, the Netherlands and Germany) to improve the comfort - usually privacy - of accommodation in hospital. Policies may also allow freedom to choose any hospital in Switzerland, including those not on the canton lists used by the CBSI scheme. Treatment by chief physician may be also guaranteed. Unlike French supplementary insurers, only one Swiss supplementary insurer offers 'reinsurance' policies to cover user charges under compulsory insurance.⁴⁶

It is estimated that between 25% and 40% of the population purchases this extra insurance.^{47, 48} Since 1997, supplementary insurance premiums have been related to risk, and are set at a level which in many cases the average person cannot afford.⁴⁹ However, as the standard of medical care cover provided under compulsory insurance is high since the 1996 law, the available margin of supply for supplementary insurance has reduced significantly.⁵⁰ In other words, supplementary insurance is not considered necessary in order to obtain a reasonable standard of care.

Sickness, Old Age and Disability Insurance.

The final component of the Swiss health insurance system comprises compulsory sickness, old-age and disability insurance. These are funded through mandatory income-based employer and employee contributions according to the social insurance model.⁵¹ These policies financed nearly 7% of healthcare expenditure in 1997.⁵²

HEALTHCARE PROVISION

The insured have freedom of choice among recognised healthcare providers, with the proviso that treatment costs are paid for by insurers up to official tariff levels. In turn, ambulatory service providers have freedom to establish where they wish. Perhaps as a result, physician density varies considerably – more being found in urban areas and around university hospitals. Doctors and other medical professionals are organised in cantonal and federal medical associations. These bodies negotiate fees and represent the interests of members in the political sphere. The Swiss Medical Association regulates and accredits postgraduate medical training.⁵³

Physician / population ratio is just below the EU average but is considered too high by Swiss policy makers.⁵⁴ There is a *numerous clausus* in four cantons which allows their universities to control numbers entering the profession through an entrance exam.⁵⁵

Primary Care

Independent practice doctors provide most ambulatory care. Of 23 679 active doctors in 1998, 13 357 (56%) were private office-based doctors, about 36% of these were GPs and 46% specialists. In principle there is unlimited free choice of physicians and dentists. Nevertheless, most Swiss have a regular doctor. Outpatient treatment is provided in a range of private surgeries (independent GPs and specialist physicians), in certain hospital units and in polyclinics. HMO-style self-financed medical centres can also be found in some large towns.⁵⁶ There is no compulsory gatekeeping, but although ambulatory specialists are easily accessible, most patients are referred to hospital-based specialists.⁵⁷

Ambulatory doctors, who are paid fee-for-service, itemise services on an invoice after each episode of care. Then, taking into account the deductible and the 10% ambulatory care co-payment, the third party payer reimburses the doctor or the patient – depending on the nature of the insurance policy. Fees are based on a nationally agreed fee schedule like that used in Germany. Point values are negotiated annually by associations of insurance funds and professional associations, and are set out in a fee schedule. The price attached to the point value is negotiated on a

cantonal level.⁵⁸ GPs in 13 cantons have freedom of prescription. They take advantage of this and on average derive roughly one third of income from prescribing. These dispensing doctors are not found in the French and Italian cantons, where pharmacist supply is higher.

The managed care model of ambulatory care is increasingly advocated as a cost containment measure. About 3792 doctors (c7%) work in the General Practitioner Network system covering 350 000 people.⁵⁹ There are about 10 Swiss HMOs, staffed by roughly 140 doctors and covering about 98 400 insured people. HMOs are group practices employing GPs and specialists in internal medicine, gynaecologists, plus other nurses, physiotherapists, etc. The doctors in HMOs refer patients to particular specialists and hospitals but the patient still has some free choice.^{60 61} There is some disagreement over whether satisfaction among those using HMO services is as high as those not doing so.

Hospital care

The Swiss benefit from a generous hospital infrastructure. In 1997 there were 406 hospitals in Switzerland. Of those 272 were public or publicly subsidised (not-for profit) private. Five were university hospitals. With 5.6 beds per 1000 population, the Swiss are amply provided with hospital beds. Lengths of hospital stay are comparatively high. Perhaps because of this, the proportion of total health care expenditure spent on hospital care is the highest in Europe. Unlike other countries this excess supply has not yet been reeled-in.

For planning and funding purposes, secondary care can be divided into two parts. The federal government has no planning authority for outpatient and short-stay inpatient care and does not provide subsidies for it. Inpatient care on the other hand, is subject to state planning and receives public subsidies. Zweifel notes that as a direct consequence of the contributions from the state, the hospital region and the canton, SwF.1 invested locally into a hospital triggers five or more SwF of matching grants; an excellent multiplier by any standard. Thus, the system does not always provide incentives for treatment that is optimal for health and economically efficient.⁶² Health insurance providers, for example, will tend to favour inpatient treatment since some of the cost is borne by the state.

Hospitals are operated by public (cantons, local authorities or associations of local authorities, or independent foundations), or private institutions, which can be managed either on a profit-making or not-for-profit basis. Most inpatient treatment is provided in cantonal or regional hospitals.⁶³ Cantons must plan hospital care according to local needs and generate a list of accredited hospitals that are entitled to reimbursement under the compulsory insurance.⁶⁴ These official canton hospital lists are drawn up based on bed requirements – the target number of beds per 1000 population varying between 2.6 and 3.5 beds (for 2005).⁶⁵ If not on the list, a provider organisation is ‘economically finished’.⁶⁶ Private hospitals which are included in the canton’s hospital list can receive reimbursement for services under compulsory health insurance.⁶⁷ However, (new) private organisations can find it hard to get on local cantonal lists.

Hospital accommodation is of three types: ward (*allgemein*), semi-private (*halb-privat*) and private (*privat*). Wards have 4-8 beds, semi-private rooms have 2 beds, while private rooms have only 1 bed. All city and canton hospitals have all three types. Basic insurance entitles patients to treatment in a ward of a public or non-profit hospital in their canton of residency. Supplementary insurance policies provide the gateway to greater privacy, the for-profit private sector, and to hospitals in other cantons.

In theory there is competition between hospitals, but Zweifel contends that in practice there is choice (of type of hospital and level of privacy), but not real competition.⁶⁸

Hospital finance provides a good example of the diversity in Swiss healthcare organisation. Cantons and local authorities finance the better part of hospital capital investment - but also cover approximately 50% of the operating costs of ‘their’ public and not-for-profit hospitals.⁶⁹ Health insurers cover roughly 50% of operating costs, usually on the basis of a daily flat rate – negotiated annually on a canton-wide level between the sickness insurance fund association and service provider organisations. Price tariffs vary tremendously from one canton to another. This payment system is regarded as inefficient, so, aiming to improve cost control, since 1994 a few cantons have started to finance hospitals on a global budget basis, while some other Cantons are attempting to switch to a flat-rate per case financing system ‘based on all patient diagnosis-related groups (APDRGs).’^{70, 71} Hospital doctors are mostly employed by hospitals and receive a salary. Additional payments are received when treating those with supplementary insurance. A proportion of these monies is payable to the institution. Co-payments for hospital treatment are limited to the abovementioned hotel expenses charge of SwF 10 per day levied on those from single occupant households.

Pharmacy

One third of Swiss pharmaceuticals are on a positive list and are reimbursed by basic insurance, subject to a 10% co-payment. All other drugs are either paid for in full by patients, or by supplementary insurers if applicable. The Swiss pay heavily for drugs and there is now a drive to increase the use of generics. The government advises patients to ask doctors and pharmacists to substitute their prescriptions with generics whenever possible.⁷²

Thus far we have seen how Swiss health care is financed and provided. Largely owing to Federal decision-making procedures, Swiss health care has only really experienced one major reform – that of 1994. Written following submissions by four economists (including Zweifel), the new law was presented to referendum voters as a quality enhancement and cost-saving measure, and brought in competition in social health insurance along with the possibility of selective contracting.^{73 74} Professor Zweifel, who only agreed with 50% of the new law's content, has set out the implicit aims and expectations that lie within this act. Relying on his notes and a public presentation in November 2001, the following section of this piece presents these aims and expectations, contrasts them with the reality of Swiss healthcare today, and suggests some solutions to obvious problems.

THE REVISED HEALTH INSURANCE LAW OF 1994: Hopes, aims, expectations

The numerous actors in Swiss health care had a variety of expectations of the Revised Health Insurance Act. These were as follows:

The Federal government hoped to reduce subsidization of health insurance premiums (paid to 97% of the population) through the 1994 Act by:

- making subsidies means-tested (targeted grants to individuals rather than to all local members of each company)
- requiring matching contributions from the cantons
- mandating cantons to draw up lists of accredited hospitals for contracting with social health insurers
- obtaining the authority to develop uniform fee schedules for physicians and hospitals.

Cantonal governments hoped to relieve their public purse through the 1994 Act by:

- retaining authority to implement the means-tested subsidy
- retaining authority over hospital policy
- fixing their share of hospital finance to 50% of the running cost of public wards.

Local authorities hoped they would not be affected by the 1994 Act.

Medical associations were willing to trade off the undermining of the 'any willing provider' clause (thereby allowing innovative managed care projects) for a substantial extension of covered health care benefits.

(Potential) patients expected the new 1994 Act to improve the benefit-cost ratio in health care through

- a stabilization or even a decrease of premiums thanks to price competition between insurers
- a better match of coverage with their preferences thanks to product competition.

THE REVISED HEALTH INSURANCE LAW: The reality... problems, spiralling costs, imperfect competition.

Switzerland experiences some of the same problems as any developed country: the most serious being spiralling healthcare costs. Although satisfaction is very high and less dependent on income than satisfaction in the US, care is very expensive and arguably does not produce value for money. In light of this increasing expenditure, policy makers and commentators are starting to question what level of health care the Swiss want, and how much are they prepared to pay for it. Will rationing be necessary or accepted by voting patients?⁷⁵ Critics say that the Revised Health Insurance Law has great weaknesses and is part of problem. There is a lack of incentives for efficiency on the part of patients, and providers. The more that doctors prescribe and examine, the more they earn. Nor is there an incentive for insurance companies to develop much vaunted innovative, lower-cost insurance policies.⁷⁶ Many critics are also frustrated at competition rhetoric within the Act. Although the law provides for competitive conditions (encouraging competition amongst insurance providers as well as service providers, co-ordinated hospital planning, removing excess capacity in hospitals and promoting alternative health insurance models), they have not come to fruition.⁷⁷

FEDERAL GOVERNMENT

Swiss health care has become more and more expensive in relation to other services. Zweifel notes that this scenario would normally result in increased supply, but this has not happened. Hence there are signs of market inefficiency. Possible explanations include regulation, for example through price controls, and the 'any willing provider' clause, which largely blocks price competition between physicians. Secondly, there are the cartels of hospitals which block price competition between hospitals, and result in oversupply (110 beds per 100,000 population (US: 40)). Thirdly, there is the compulsory one-size-fits-all benefits package with community rated premiums. Finally, there is strict

prohibition of parallel imports of drugs, resulting in punitively high drug prices compared to those in the EU. These points raise the issue of the relative role of the state and the market.

The Extent of Centralisation. The system currently suffers from a lack of coordination characterised by an incompatibility of aims and problematic negotiations between health insurers (mostly active at the national level) and hospitals (forming cantonal cartels). Since 1996, regulatory powers of the central government have increased considerably, and this trend is set to continue.⁷⁸ But should planning be done at federal level? If not, how can cantons achieve better coordination? Should the state withdraw from the planning process? Suggested alternatives to the mixed level regulatory system either advocate more government centralisation or a greater role for the market. Zweifel falls squarely into the latter camp, agreeing that prices should be negotiated freely without the government's involvement and left largely to the laws of competition, with safeguards for the poor.

In 1996, the confederation obtained the authority to develop uniform fee schedules for physicians and hospitals (before, there were 26 physician fee schedules). A uniform nomenclature, TARMED, now sets fees for services. However, many of these are set too low in the opinion of private clinics among others.⁷⁹ Froelicher suggests, "[TARMED] is definitely a step in the right direction but suggests that it is time the laws of the marketplace, including safeguards for avoiding unexpected increases, were used to negotiate prices".⁸⁰ Arguing that there should be competition between purchasers and providers, Zweifel considers TARMED "A very bad idea", which stifles innovation. For example, types of payment (fee-for-service, capitation, bonuses for excellent outcomes) are optimal for (different) patient-provider combinations, but TARMED does not allow such flexibility. It restricts price competition.⁸¹

Provider Cartels. The Federation both mandates cantons to draw up lists of accredited hospitals for contracting with social health insurers, and imposes an AWP clause on insurers regarding the provision of ambulatory services by physicians. Zweifel and others call for more choice and a move away from cantonal cartel lists – to which private clinics can find it hard to gain access. Following a withdrawal of cantons from hospital accreditation, preferred provider lists could be individually compiled by (major) health insurers operating in a more perfect purchaser-provider market. Illustrating his point Zweifel adds, "The hospital may sign up with insurer A. [Not] with insurers B, C, D, but again with insurer E, F, G. You do not contract with everyone when you are in a market."⁸² Such selective contracting would signal the end of cantonal hospital cartels.

The Compulsory 'One-size fits all' Insurance Model. Owing to Federal package and price control, insurers are not free to structure their tariffs and benefits.⁸³ As a result the predicted variety of health insurance products (HMO's, GP Networks etc) have not emerged and so product and quality competition between insurers is stifled. Zweifel, who sits on the Swiss Competition Committee, suggests that: "Swiss health insurance has been in a cartel for 70 years". "A regulator now tries to administer competition but is hindered by its past and continued role as regulator." Is there a better solution?

Culturally, the Swiss like to have the best, following only the USA in their adoption of new technologies. But can such a comprehensive luxury, 'basic' benefit package be maintained for all? Some, notably including the insurers, suggest that the 'basic' benefits packages should be thinned – distinguishing between the desirable and the essential. Thus treatments for lifestyle and minor medical conditions may be limited, and there would be more room for product competition beyond a restricted 'basic' package. Only then would the insurer cartel be broken up.

Health Insurance Premiums. The Federation aimed to ensure affordable premiums for all through community rating and individually targeted subsidies, in excess of 8-10% of taxable income. Zweifel "*one of the godfathers of competition*"⁸⁴, argues in favour of a return to risk-dependent premiums in social health insurance. Premium regulation creates strong incentives for risk selection and the risk adjustment scheme leaves little incentive for product innovation. For example, managed care schemes with lower premiums that would normally attract the young and well-educated, are accused of cream-skimming and penalised by the risk-adjustment scheme. He would "*Let competition work its magic. Let those who are a bad risk get the message that they need to become better risks, if possible. If not possible, [they should] still get a subsidy which gets [them] down to little more than 8-10 per cent of taxable income*".⁸⁵

Finally, Zweifel suggests the lifting of the domestic purchasing principle as a further solution. In general, Swiss public procurement is subject to EU norms but this does not apply to the purchasing of health care by social health insurers. If possible, why not pay less for care in Majorca?

CANTONAL GOVERNMENTS

The Cantons hoped to relieve their public purse by gaining more subsidies from the federation in light of the 1994 law. However, this aim contradicted the objective of federation, and came to nothing. Cantons were more successful in their efforts to retain the authority to implement the means-tested subsidy to the insured.

At least in the short term the Cantons also succeeded in retaining authority over hospital policy. They continue to decide fees and investments. Zweifel argues that this Cantonal control is incompatible with the concept envisaged in the new Act, of insurers as “prudent [healthcare] purchasers”. A solution would be to withdraw cantons from hospital finance. Otherwise, fear of cost shifting will prevent negotiation of preferred provider agreements with insurers.

PROVIDERS AND MEDICAL ASSOCIATIONS

Following sustained lobbying by the rather ominously dubbed ‘Blue Front’ (hospital and physicians associations) providers were willing to trade off the undermining of the ‘any willing provider’ clause (thereby allowing innovative managed care projects) for a substantial extension of covered health care benefits by Parliament. In doing so they guaranteed members an equal if not higher income by increasing likely turnover of patients. It is perhaps no coincidence that their concern over the threat posed by insurer purchasing innovation may have gone some way to creating the environment that strangles just that innovation.

Secondly, it should be noted that the fee-for-service payments system encourages physicians to treat patients perhaps more than is medically necessary. Whatever the incidence of this supply led demand, irresponsible provision only exacerbates the spiralling expenditure on health in Switzerland. Thirdly, the relatively limited range of non-doctor providers of primary care – such as nurses, forces patients to use the services of perhaps ‘over-qualified’ and expensive personnel for matters which could perhaps be treated more cost-effectively by someone else.

(POTENTIAL) PATIENTS

The insured were hoping for an improved health care benefit-cost ratio through a stabilization or even a decrease of premiums thanks to price competition between insurers. This has not happened; ‘In the 1990s, public bodies’ efforts to economise led to a decrease in expenditure by the cantons and local authorities, while health insurers’ expenditure clearly increased. This resulted in massive rises in premiums and a consequent increase in the burden on private households.’⁸⁶ Patients had hoped for a better match of coverage with their preferences thanks to product competition between health insurers. What they got was a comprehensive uniform package, with very little product competition. As far as the insured are concerned, “More competition-lower prices”, has not worked, yet.⁸⁷ So far, post-1996 competition has not satisfactorily favoured patients as consumers.

Irresponsible use of services – perverse incentives.

Zweifel comments that, by offering perverse incentives, such as the 1=5 match funding system, local laws will always be passed in referenda because ‘somebody else will pay’. It is perhaps partially owing to this characteristic attitude, that Swiss patients, particularly those with *franchise ordinaire* policies can easily be accused of excessive use of medical services: At 11 per year in 1997, the number of doctor contacts per person is the highest in Western Europe. A variety of explanations for this include the following: high density of providers, which provides unrestricted access to physicians for what might be trivial complaints; a culture that emphasises a high level of utilisation of health services (and notably varies from one language group to another – the francophone being the heaviest users); and finally, a lack of negative financial incentives for individuals to reduce utilisation – such as more “no claims bonus” policies.⁸⁸

CONCLUSION

Since the 1994 Health Insurance Act, a frustrated insurer cartel, despite many mergers has maintained something of a status quo position, while providers – with the obvious exception of would be private hospital market entrants are the clear winners. It appears that on the whole patients have been the losers since the 1994 Act. While on a par with, or even ahead of the Dutch in competitive terms, there are calls for more effective competition in Swiss health care. This will require the laws of the market place to be unleashed in each of the three Swiss healthcare markets (patient-provider, patient-insurer, insurer-provider). That said, Swiss attachment to universality guarantees an extremely good quality of care to all with little if any rationing. Although Zweifel is very critical of Swiss healthcare, somewhat paradoxically, he is also certain that they have come up with the best solution in the world. And rather than regarding NHS style and centralised uniform social insurance style systems (such as the French) as beyond the pale, he believes that they are a necessary stage, a good first step, on the way to something else – something better: enabled competition and mandatory private insurance. It is clear that there is much to learn from Swiss healthcare now, but that we must also watch future reforms carefully to determine whether they can make improvements in efficiency by ridding health care of competitive imperfections.

Swiss Lessons for UK Policy-Makers:

- The adoption of market forces in healthcare can serve everyone, including the poorest in society.
- Like monopolies, cartels involved in the provision of any good or service generate inefficiency and stifle innovation. Competition can lead to greater efficiency and ultimately to better standards of healthcare for all.
- Governments should regulate healthcare. They need not both pay for and provide it.

1. Swiss health care demonstrates that **Governments need not be the single payer**. Through their unusually mixed system of private and public contributions, the Swiss maintain a price mechanism which permits all people to influence the flow of funds into the system and avoid the widespread rationing typical of the UK. As a result, health expenditure is among the highest in the world. The interests of patients are served by a third-party payer of their choice to which they pay visible, if regulated contributions. Policies that may be offered by social health insurers include the conventional, variable deductibles, bonuses for no claims, managed care on so on.
2. **The Swiss are price-conscious**. In addition to the mixed source of funds, price consciousness is enabled through premium competition between insurers, choice of level of deductible, and co-payment. Subsidised dependent people are also as price-conscious as circumstances allow. Many of the Swiss also want to be product and quality conscious too, but the existing state controls over premiums and benefits do not allow effective choice.
3. **Governments should not impose a single provider** – because consumers cannot escape bad service. There is substantial private ownership of hospitals in Switzerland as well as a large number of independent GPs and specialists who operate from their own clinics. Through unlimited consumer choice of physician, the system encourages doctors to serve their patients, and so, the quality of medical service supply is guaranteed by the market. Unfortunately, competition is less effective in the hospital sector, where cantonal cartels have forced up prices.
4. **Since the first health insurance law of 1911, the Swiss decided to avoid a compulsory link with employers** – because it makes it harder to move towards systems based on responsible consumers. If someone else seems to be paying, personal responsibility is diminished.
5. **The Swiss recognise the special nature of health care** – it is partly a moral necessity and partly an ordinary consumer good. They aim with much, though not unqualified success to make the market serve everyone, whether they are self-supporting through work or not. However, the element that is like other consumer goods is vulnerable to over-supply and over-use when provided at very low cost. Perhaps by having more choice of benefits packages and providers, consumers will assume even more personal responsibility?
6. **The Swiss ensure that people dependent on government support do not have an obviously inferior service**. In practice, Switzerland applies a market test. They recognise that the state cannot guarantee the standard of care enjoyed by the rich and so it cannot honestly promise an equal service without suppressing all private health care. Through careful use of targeted subsidies on private insurance premiums Switzerland guarantees a standard chosen by people on middle incomes who are spending their own money. That standard is very high. By combining insurance and solidarity, the Swiss ensure that the most disadvantaged people in society enjoy the same level of care as the working and middle classes.

On 2 November the UK Health Policy Reform Group (HPRG) heard Prof Peter Zweifel, economist at the University of Zurich, give a seminar on the Swiss approach to competition in health care. This discussion paper incorporates the central tenets of his arguments.

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