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DOI: https://doi.org/10.1215/03616878-25-5-937

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Switzerland, a country with a population of approximately 7 million, is of interest in comparative health policy for at least three reasons. First, consumer preferences regarding health care are respected to a degree found only in the United States—with similar consequences in terms of health care expenditure. Second, Switzerland has a very decentralized political system, especially when it comes to matters of health policy. And third, the new Law on Health Insurance (LHI) of 1994, which survived the test of a popular referendum in 1996, has introduced managed competition into the health care sector to an extent that seems to at least parallel the other two well-known examples, Belgium and the Netherlands (Schokkaert 1996; van de Ven and van Vliet 1992).

Overview of Switzerland's Health Care Sector

Political power is very decentralized in Switzerland. The confederation is responsible for social health insurance, which has become mandatory for the entire resident population under the new LHI. However, authority for health policy continues to be vested with the twenty-six cantons (member states) that mainly act as financiers of public hospitals. The cantons also pay contributions toward operating costs and provide investment grants to private hospitals that admit patients with social health insurance. Some public health services are financed (and, in part,

Journal of Health Politics, Policy and Law, Vol. 25, No. 5, October 2000.

Table 1 Key Data for the Swiss Health Care Sector

	1970	1975	1980	1985	1990	1995	1997
A. Nominal share of Health Care Expenditure in GDP (%)							
Switzerland	4.9	6.6	6.9	7.7	8.3	9.6	10.1
Germany (West)	6.3	8.8	8.8	9.3	8.7	10.4	10.4
Great Britain	4.5	5.5	5.6	5.9	6.0	6.9	6.7
United States	7.3	8.2	9.1	10.6	12.6	13.6	13.6
B. Real share of Health Care Expenditure in GDP (%)							
Switzerland	6.4	7.4	7.1	7.6	8.3	9.2	9.4
Germany (West)	7.2	9.7	9.5	9.3	8.7	10.4	na
Great Britain	4.8	6.3	6.4	6.5	6.0	6.3	na
United States	9.3	10.7	11.2	11.9	12.6	12.3	12.1

Source: OECD 1998.

provided, especially in the case of nursing homes for the aged) by more than 3,000 communes.

It has become customary to compare countries in terms of the share of their GDP devoted to health care expenditure (HCE). Part A of Table 1 shows that Switzerland occupies an upper-middle position, comparable to Germany's. The contrast to Great Britain, with its National Health Service, is commonly interpreted as evidence of inefficiency. Indeed, there are indications to this effect:

Lower Real Than Nominal Share of HCE in GDP. As evidenced in part B of Table 1, Switzerland's real health share has recently been lower than its nominal counterpart. This means that the health services deflator has had a higher value than the GDP deflator. Thus, providers of health care services may enjoy rents, that is, incomes in excess of what is necessary to make them continue their activity rather than changing their profession or rehiring.

High Average Price of Drugs. Part of the high relative price of HCE can be traced to the fact that drugs command a higher price in Switzerland than in most OECD countries as a result of the prohibition of parallel imports.

High Share of the Hospital Component of HCE. The particularly high relative price of hospital services has a great impact on the HCE deflator, since some 48.5 percent of total HCE is devoted to hospitals, a very high figure in international comparisons (Federal Statistical Office 1997: 43). Given the high degree of retrospective subsidization by most cantons, the incentives for cost containment by hospitals are very weak.

Structural Features on the Supply Side. It has proved impossible for cantonal governments to close a hospital department, let alone an entire hospital. This keeps hospital density at a high 113 patients per 10,000 inhabitants, compared to 41 per 10,000 inhabitants in the United States as of 1995 (OECD 1997). Given that cantons finance investments to the tune of up to 80 percent, a community hosting a hospital may get five Swiss francs for each franc it spends on the modernization or extension of its hospital.

On the other hand, the increasing HCE share in total income may reflect preferences of consumers—an interpretation that should not be dismissed lightly, for at least three reasons: First, research on the determinants of HCE by industrial countries invariably ascribes a decisive role to income (e.g., Gerdtham et al. 1992), regardless of the organization of their health care sector. High elasticity estimates point to health care as a luxury good. Second, industrial countries continue to exhibit an increasing rectangularization of their survival curves. In Switzerland, for example, no less than 92 percent of the cohort of women born around 1950 are estimated to reach the age of seventy, up from 86 percent twenty-five years earlier (Bopp and Gutzwiller 1998). This seems to reflect an ever-increasing degree of control over health status, which certainly is in the interest of risk-averse individuals. And third, unlike people in the United States and other industrial countries, Swiss individuals can express their preferences with regard to their future consumption of health care very directly because social health insurance has always been individually contracted. Thus, employers do not intervene as (imperfect) agents of consumers, aggregating preferences in ways that are difficult to reconstruct.

The Quest for Reform and the New Law on Health Insurance

The new LHI was promulgated in 1994 and passed a popular referendum in 1996. It sought to relieve federal and cantonal government from some of the burden of HCE, although the share of public HCE in total HCE never exceeded 30 percent after 1980. This objective has been attained, as the share of public HCE dropped from 29.8 percent in 1990 to 25.8 percent in 1996 (see part A of Table 2), which is very low compared to other industrial countries (in the United States, for example, it is around 40 percent; see OECD 1997).

A major attempt at reform had failed in 1974, the reason implied by part B of Table 2. It shows that the confederation had been withdrawing systematically from the financing of public HCE, mainly by cutting back

Table 2 Size and Structure of Public Health Care Expenditure (HCE) in Switzerland

	1970	1975	1980	1985	1990	1995	1996
A. Share of private HCE (%)	66*	68*	71*	70.6	70.2	72.2	74.2
Share of public HCE (%)	34*	32*	29*	29.4	29.8	27.8	25.8
B. Structure of public HCE (%)							
of the confederation	18.3	14.0	14.4	10.7	9.1	12.2	14.8
of the cantons	64.4	67.5	59.4	40.5	60.5	53.3	52.7
of the communes	17.3	18.5	26.2	28.8	30.4	34.5	32.5

Source: Pharma Information 1997.

*Author's estimate, based on the assumption that within social insurance a constant 7 percent of HCE (the average value after 1985) is controlled by (1) the public scheme for old-age provision, (2) accident insurance, and (3) military insurance. The remainder is payments by competing sick funds, which are allocated to private HCE.

the per-enrollee subsidy it paid to the sick funds, which acts as social health insurers. In the 1970s, the burden was shifted to the cantons, which may have been a cause for their militating against the 1974 bill. Beginning in the later 1970s, the cantons were able to make the communes (which are not represented as such in federal parliament, contrary to the cantons) responsible for a greater share of public HCE. To protect the interests of the cantons, the new LHI requires sick funds to cover 50 percent of the operating cost of hospital services included in the basic package.

Thus the motivation for the new LHI especially on the part of federal politicians was to shelter their budgets from future demands coming from health care. To win voters' support of the bill, the declared aim of the reform was to marry efficiency with equity. Two features of the new law were designed to accomplish this purpose:

Means-Tested Subsidy of Health Insurance Premiums. Previously, a per-enrollee subsidy was paid to the sick funds in return for their acting as regulated carriers of social health insurance. Now, cantons were mandated to fix a benchmark ratio of premiums to taxable household income (typically between 8 percent and 10 percent), beyond which households receive a premium subsidy. The confederation was to provide matching grants.

Competing Sick Funds as Prudent Purchasers. The new law eliminated the "any willing provider" clause with regard to physicians. This opened the way to the creation of HMOs and PPOs, ending an era of uniform contracts that had lasted eighty years. Now, competition can be counted on to force providers to come up with products having a favorable benefit-cost ratio, but not necessarily with minimum cost (in combination with low-

Table 3 Final Sources of HCE Finance in Switzerland

	1985	1991	1995
Households (%)	62.2	61.4	65.1
Out-of pocket payments	30.8	29.0	25.9
Payments to insurers	31.5	32.4	39.3
Public contribution (%)			
Confederation	7.1	6.9	8.2
Cantons	17.5	18.1	14.8
Hospitals, home care	15.1	15.7	13.3
Communes	2.8	3.2	2.2
Total public contribution (%)	27.4	28.2	25.2
Others (employers, workplace accident insurance) (%)	10.4	13.6	11.9
Total	100.0	100.0	100.0

Source: Federal Statistical Office 1997: 39.

ered quality), as politicians had hoped. Of course, voters were also disappointed when premiums rose quickly after the implementation of the LHI, though that was largely the consequence of a still-more-comprehensive basic package of covered services mandated by parliament.

The data in Table 3 are not fully compatible with those of Table 2 because they eliminate double counting among the different levels of government. Yet these data do suggest that the impact of the new LHI has been to shift the financial burden to households in the guise of increased payments to insurers (premiums). On the other hand, out-of-pocket payments have decreased due to the extension of the basic package. It should be noted that the figures do not mean that one-fourth of the health bill is borne by patients in the event of illness. An unknown (but substantial) part of out-of-pocket payments is for private accommodation in the hospital, which most often is reimbursed by supplementary health insurance. Conversely, the total public share of HCE has decreased, from roughly 28 percent to 25 percent. This does not imply increased regressivity in financing, however, because the additional funding from the confederation is now targeted to lower-income households in the guise of premium subsidies.

With targeted premium subsidies, it would have been possible to let social health insurers calculate their premiums according to true risk while exposing them fully to competition. High risks would have had to pay high premiums, but would also have received a substantial subsidy whenever premiums exceeded the 8–10 percent benchmark share of

income. Instead, the new LHI stipulates that a given sick fund must charge a uniform premium to all adults of a given region. The official justification was increased price transparency and lowered switching costs for consumers; however, politicians may also have feared unexpected surges in subsidies caused by those individuals classified as high risks.

Of course, uniform premiums create strong incentives for risk selection, which is prohibited by the LHI. As a countermeasure, a risk-adjustment scheme was introduced in 1993. But the risk-adjustment formula contains only age and sex as predictors of future HCE. Such a formula is known to have very low predictive power (van de Ven and van Vliet 1992; Beck and Zweifel 1998). One way to attract low risks in a given age and sex group may be the creation of new forms of provision. In fact, Konstantin Beck (1998) argues that the rapid expansion of HMOs and PPOs in Switzerland (with a market share still below 10 percent at the time of writing) may serve this purpose rather than the objective of improving the cost-benefit ratio in the interest of consumers.

The Future of Managed Competition in Switzerland

The reform of Swiss social health insurance that was implemented in 1994 and accepted by the voters in 1996 reflected the wish of politicians to reduce the burden of HCE on their budgets. This shift need not fall on the poor, because low-income households receive a subsidy once the premium for social health insurance exceeds a limit in the order of 8–10 percent of taxable income. The reform would have permitted full price and product competition, but the new LHI imposes uniform premiums for adults of a given region, strengthening insurers' incentives for "cream-skimming," which are only partially neutralized by a risk-adjustment scheme. Overall, the reform could be judged weakly pro-competitive in that it gives sick funds the freedom to develop new products and to select physicians with a favorable cost-benefit ratio.

Thus the future of managed competition seems to hinge importantly on improvements of the risk-adjustment mechanism. In view of the fact that a major part of lifetime HCE occurs during the last year before death, the mortality rate could be included in the formula (Beck and Zweifel 1998). Alternatively, prior hospitalization may be used (Lamers 1997). But two additional problems must be solved for managed competition to work. First, cantons need to withdraw from hospital financing that will permit hospital management to conclude preferential contracts

with health insurers. Preferential contracts would provide hospitals with market signals, encouraging specialization in areas of comparative advantage. On the other hand, a hospital unable to contract with any competitive insurer would have to close down. HMO and PPO patients would profit from lower rates, and quite likely improved quality, due to increased volumes of procedures of a given type.

The second condition for success is to stop ongoing attempts on the part of both sick funds and cantonal medical associations to create a uniform fee schedule. Such a schedule eliminates price competition in spite of the abolition of the "any willing provider" clause by the new LHI. Admittedly, individual schedules for each contract between a single insurer and a group of health services providers may cause excessive administrative costs; the proper alternative should not be to create a single uniform fee schedule but a choice among several standardized schedules.

In spite of the clouded horizon, the idea of choice is now firmly rooted in the thinking of all parties concerned. Consumers are increasingly learning to compare conventional medicine with the managed care alternatives offered to them; social health insurers compete much more intensely for enrollees; physicians are getting slowly accustomed to the concepts of evaluation and quality assurance; and hospitals are becoming interested in treatment alternatives that are less costly in order to meet insurers' demands. At the very least, there is a willingness to try out new solutions that had not been known for decades in Swiss health care.

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