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# The Swiss Health System

## Regulated Competition Without Managed Care

Uwe E. Reinhardt, PhD

**H**EALTH SERVICES RESEARCHERS AROUND THE GLOBE have known for decades that the United States, with a comparatively young population, spends much more on health care than do other nations<sup>1,2</sup> (TABLE). As US annual health spending continues to exceed that in comparable nations by ever wider margins, and as US health policymakers begin to run out of ideas for how to constrain that growth, interest in the performance of health systems abroad has increased in recent years. One need not import another country's political system or social ethic to learn from the techniques they use to seek cost-effective health care. Cost-effective health care delivers the maximum attainable benefit for a given sacrifice of resources or, alternatively viewed, minimizes the sacrifice in resources for a given level of benefits. While economic circumstance and a preferred social ethic may lead some nations to spend more on health care to achieve higher levels of benefits than others, in principle, all nations should strive for cost-effective health care at whatever level of health spending they have chosen.

Americans who are not in favor of government-run health insurance may find the German, Dutch, and Swiss health systems of special interest. None of these nations relies on government-run health insurance as in the model of the Canadian provincial health insurance plans or the US Medicare and Medicaid/State Children's Health Insurance Program programs. All 3 have flirted in recent years with elements of price-based consumer choice, albeit within a framework of strictly regulated competition.

The Swiss, for example, have experimented with consumer choice in the market for health insurance. In their article in this issue of *JAMA*, Herzlinger and Parsa-Parsi<sup>3</sup> examine that system in detail and conclude that it delivers a superior, more cost-effective, and more equitable performance than does the US system. They believe that "the positive results achieved by the Swiss system may be attributed to its consumer control, price transparency of the insurance plans, risk adjustment of insurers, and solidarity."

It is difficult to argue with the assertion by Herzlinger and Parsa-Parsi that, relative to the US health system, the Swiss

system delivers an overall superior performance. Much the same can be claimed by many other foreign health systems because, in cross-national comparisons, the higher US health spending has not translated into consistently superior quality of care<sup>4</sup> or in greater satisfaction among patients,<sup>5</sup> physicians,<sup>6</sup> and hospital executives.<sup>7</sup> Furthermore, the United States has consistently ranked relatively low on most traditional health status indicators, such as life expectancy and infant mortality. These population-based health status indicators are driven by numerous socioeconomic variables besides health care and cannot be used as a reliable indicator of health system performance in cross-national studies.<sup>8,9</sup> Even so, it is troublesome that on the metric of potential life years lost per 100 000 population (due to premature death that could have been avoided through timely and appropriate health care, public health measures, and less risky behavior), the United States was estimated by the Organisation for Economic Cooperation and Development (OECD) to have lost 5120 lives per 100 000 in 2000, while the comparable numbers were 3888 in the United Kingdom, 3806 in Germany, 3571 in Canada, and 3400 in Switzerland.<sup>2</sup>

The superior performance of the Swiss health system is not necessarily attributable to the role of consumer choice in that system. One can just as plausibly ascribe that performance to the pervasive government regulation that guides the Swiss health system. In fact, the Swiss health system in its current form reminds this author of nothing so much as the Clinton health security plan, which also called for market-driven consumer choice within a framework of government regulation.

### The Swiss Health System

Switzerland's 7.2 million inhabitants reside in 26 cantons that enjoy authority over all matters not explicitly transferred to the Confederation, Switzerland's federal government. Following that constitutional structure, health policy for most of Switzerland's history has been left to the authority of the cantons. Until the mid 1990s, therefore, the Swiss health system was merely a mosaic of 26 distinct cantonal health systems.

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See also p 1213.

**Table.** Health Spending in 2002<sup>2</sup>

Country	Health Spending per Capita, PPP \$*	% of Gross Domestic Product
United States	5267	14.6
Switzerland	3445	11.2
Canada	2931	9.6
Germany	2817	10.9‡
France	2736	9.7
Netherlands	2643	9.1
Sweden	2517	9.2
Australia†	2504	9.1
Italy	2166	8.5
United Kingdom	2160	7.7
Japan†	2077	7.8

\*PPP \$ indicates purchasing power parity international dollars.

†Data are for 2001.

‡This number is high because the former East Germany contributed proportionately less gross domestic product to the unified Germany than added health spending.

Swiss health care became more centralized and nationally uniform after passage in 1994 of the federal *Krankenversicherungsgesetz* (Health Insurance Law), which took effect in 1996 and has been revised once, with a second revision currently under discussion. With that legislation, the federal government imposed more uniform national standards on the cantonal health systems and, at the same time, sought to achieve greater social solidarity.

The 1994 Health Insurance Law made compulsory the purchase by households of private health insurance coverage for a mandated, fairly comprehensive package of health benefits. Households can choose their insurance from 1 of more than 90 private insurance carriers, although three quarters of the population are covered by 15 large carriers, 1 of which enrolls more than 15% of the Swiss population.<sup>10</sup>

To compete in the market for compulsory health insurance, a Swiss health insurer must be registered with the Swiss Federal Office of Public Health, which regulates health insurance under the 1994 statute. The insurers were not allowed to earn profits from the mandated benefit package, although they have always been able to profit from the sale of actuarially priced supplementary benefits (mainly superior amenities).

Choice in the Swiss market for compulsory health insurance is confined largely to a trade-off between cost sharing for the mandated benefit package and the premium charged for that coverage by the carriers. The form of cost sharing that can be offered for that standard package is confined by law to a finite set of standard policies that vary mainly by the level of the annual deductible. Each insurer is free to set the premium for each type of policy, albeit subject to 2 restrictions.

First, the premium for a particular type of policy sold by an insurer is community-rated for that insurer, which means that a 25-year-old and an 80-year-old individual pay a given insurer the same premium for the same type of policy (Luca Crivelli, PhD, Department of Economics, University of Lugano, Switzerland, written communication, August 4, 2004).

Premiums for children up to age 18 years and students up to age 25 years are somewhat lower but are community-rated within those categories. Second, although individual insurers can set their own premiums for a particular type of policy, those premiums are subject to audit by the Federal Office of Social Insurance, which has the power to reduce the proposed premiums. Evidently, Swiss insurers have far less freedom to vary the health insurance products they offer and to set the premiums than do US private insurers.

By law, Swiss insurers currently can vary the annual deductible (called franchise) from a mandated minimum of SFr 300 to SFr 400, SFr 600, SFr 1200, or the legislated upper limit of SFr 1500. (A Swiss franc is currently worth about US \$0.80 on the spot exchange market.) Currently proposed legislation would raise that upper limit to SFr 2500 (Luca Crivelli, Department of Economics, University of Lugano, Switzerland, written communication, August 4, 2004). The federal government also regulates the maximum discount off the standard premium for the lowest deductible that can be offered the insured for higher deductibles.

In addition to the deductible, all insured individuals pay a coinsurance rate of 10% on all health care included in the standard package, up to a maximum of SFr 700 per year. Proposals currently before the legislature would increase that coinsurance rate to 20% but with the same upper risk exposure of SFr 700. Insurers may also offer so-called bonus policies, under which premiums for a specified year are reduced if the insured individual did not use covered health services in the previous year.

In addition, Swiss insurers may offer the insured 2 types of managed care products: (1) a general practitioner (GP)–gatekeeper network model that requires the general practitioner's approval for ambulatory care visits to specialists, and (2) restricted networks of providers, on the model of the US health maintenance organization (HMO). All other policies remain subject to an "any-willing-provider" structure (compulsory contracting), which guarantees all physicians with the proper professional credentials unfettered access to the insured patients of all competing health insurers and, at the same time, offers patients free choice of physicians. The bulk of Swiss health care is still being delivered under those terms.

Because, by law, Swiss health insurers must enroll all applicants at the set community-rated premiums, the carriers may end up with risk pools for which actuarial costs *ex post* exceed or are less than that premium set *ex ante*. To alleviate the resulting inequity, there is a postenrollment risk adjustment under which insurance carriers with a relatively costly risk pool are compensated by carriers with relatively low-cost risk pools. This risk-adjustment mechanism, which is based on only enrollees' age and sex, is similar to that used in Germany and still leaves some room for subtle marketing techniques to attract favorable risk pools.

Unlike the Dutch and German social insurance schemes, in which premiums are collected at the nexus of the pay-

roll and based strictly on ability to pay, Swiss citizens purchase health insurance individually (ie, not through an employer) and pay a per capita premium. That approach is particularly burdensome for large families. As a gesture toward social solidarity, low-income families receive a means-tested government subsidy toward their insurance premiums, with the aim of keeping the net outlays for premiums below 8% to 10% of family income, depending on the canton of residence. Despite of these subsidies, the per capita premium, coupled with the high degree of cost sharing by patients at point of service, has earned the Swiss health system the label of the most regressive health financing in a recent study of 12 comparables in OECD countries.<sup>11</sup> Current proposals before the legislature seek to reduce the regressivity of health care financing in Switzerland.<sup>12</sup>

Although households in Switzerland are offered meaningful choice in the market for health insurance, it appears that there is considerable inertia in that market. This inertia may help explain the remarkably high variance of premiums within cantons for the same type of health insurance policy.<sup>13</sup> One would not expect such differences in price to persist in a competitive market. A recent survey revealed that only a “minority, mostly younger population groups, have taken advantage of the ability to switch among insurers,” even though the premium discounts for higher deductibles can be large.<sup>8</sup> Furthermore, only about half of the respondents to the survey could indicate the monthly premiums they currently pay for their health insurance, which does not point to the alert, price-conscious consumer of consumer-choice theory.<sup>14</sup> According to official statistics, in 2001, about 45% of the insured chose the standard policy with the lowest permissible deductible of SFr 300, another 26% chose policies with the SFr 400 deductible, and only 9% chose the maximum permissible deductible of SFr 1500. About 8% of the Swiss population chose a managed care policy in that year, and the bulk of these were general practitioner–gatekeeper policies. Only 0.12% of the Swiss population chose the bonus policies.<sup>15</sup>

### **Is the Swiss System a Model of Consumer-Directed Health Care?**

On the surface, the Swiss health system may give the impression of a price-competitive, consumer-directed health care model. However, the heavy government regulation that pervades the entire system—including the health insurance sector—makes it a far cry from the vigorous, price-competitive health care market envisaged by the advocates of consumer-directed health plans in the United States. Some gestures to competition aside, the Swiss system so far has remained mainly a de facto cartel of insurers and health care practitioners who transact with one another in a tight web of government regulations.<sup>16</sup>

In the truly price-competitive health system espoused by US champions of consumer-directed health care, individual insurers would be free to negotiate over fees and other

conditions with individual hospitals and clinicians, as has long been the case in private health insurance in the United States. Furthermore, patients would be encouraged to choose their providers of health care partially on the basis of price. This is not what happened in Switzerland. For the ambulatory care sector, the cantonal associations of insurers and providers negotiate fee schedules apply to every provider and insurer in the canton. Insurers negotiate per diem rates with individual hospitals, but these prices, too, are subject to government regulation. Consumers cannot directly influence these prices, in spite of the heavy cost sharing they face. As of January 1, 2004, the individual cantonal fee schedules were replaced by a uniform national relative value scale called TARMED, leaving to the cantons only the authority to set the monetary point values for this schedule.

Switzerland's Federal Department of Home Affairs establishes the formulary for prescription drugs and sets the maximum allowable prices for drugs.<sup>10</sup> Consumer choice has no direct influence over these decisions either. The Federal Department of Home Affairs also determines which laboratory analyses and medical devices are to be covered by compulsory insurance. Finally, the cantonal authorities have the authority to plan the capacity of the hospital and nursing home sectors in the cantons. Only those on the approved list are entitled to reimbursement under compulsory health insurance.<sup>10</sup> Furthermore, public hospitals owned by the cantons receive sizable direct government subsidies, which partially insulates them from the discipline of having to manage strictly with revenue for services rendered.

Overall, then, the Swiss health system is a variant of the highly government-regulated social insurance systems of Europe—eg, Germany's system—that rely on ostensibly private, nonprofit health insurers that also are subject to uniform fee schedules and myriad government regulations. Although many employed US citizens have fewer choices among health insurers than do Swiss citizens, they typically have a greater direct influence on the prices of the health care they receive. Therefore, probably not very much of either the large differential of \$1822 in purchasing power parity (PPP) international dollars in per capita health spending in the United States compared with Switzerland in 2002 or the high quality of health care claimed for the Swiss system<sup>14</sup> can plausibly be attributed to the consumer choice facet of Swiss health care.

For one, there is a tight, positive correlation between per capita health spending and per capita gross domestic product (GDP) across industrialized nations. In 2002, US GDP per capita was 17% higher than the comparable Swiss figure. Adjustment for this difference alone can explain close to half the observed PPP \$1822 differential in per capita health spending in the 2 countries.

Can the remaining differential be explained by the much higher out-of-pocket costs borne by Swiss households? According to the 2004 OECD database, out-of-pocket payments by households constituted 31.5% (PPP \$1085) of total

Swiss national health spending in 2002. The comparable US figure is only 14.0% (PPP \$737), which may have caused much of the higher US spending in that year. That simplistic theory, however, is at variance with OECD data for other countries. In 2002, for example, out-of-pocket spending in Canada was only 15.2% of total health spending (PPP \$445), yet per capita health spending in Canada was only 85% of the comparable Swiss spending level. Out-of-pocket spending in Germany was an even lower 10.4% of total health spending in 2002 (PPP \$292), yet per capita health spending in Germany was only 81% of the Swiss figure. The comparable data for the Netherlands were out-of-pocket spending of 10.1% of total health spending (PPP \$266) but per capita health spending of only 77% of the Swiss level.

Furthermore, in spite of the relatively much higher out-of-pocket spending in Switzerland, that country actually uses more physicians, nurses, hospital beds, hospital days, magnetic resonance imaging and computed tomography scanners, lithotriptors, radiation equipment, and other real-resource inputs per capita than does the United States. If, with this higher real-resource use, total health spending per capita in Switzerland still is 35% lower than that in the United States, it must be chiefly Switzerland's much lower prices per unit of real health care resource that drive Swiss health spending to its relatively much lower level. As the authors of a recent study of health spending in the United States and in other OECD countries concluded, "It's the prices, stupid."<sup>17</sup>

But who brings about the lower prices of health care in the Swiss health system? Herzlinger and Parsa-Parsi<sup>3</sup> argue that these prices reflect the consumers' idea of "value for the money." However, the insured in Switzerland have only indirect and probably weak influence over the prices paid to clinicians, as these prices are negotiated by the cartel-like associations of insurers and clinicians under the watchful eye and heavy hand of government. Since all insurers are bound to the same prices for ambulatory care and prices are negotiated between insurers and individual hospitals for inpatient care, it is not clear how effectively consumer choice among insurers can influence the prices paid to clinicians. It can just as plausibly be argued that these prices reflect government's idea of value for the money.

Who ensures the quality of health care in Switzerland? Absent specific information on the quality of health care rendered by competing clinicians in Switzerland, it is difficult to see what direct influence consumer choice could have over the quality of health care, other than by word of mouth, as in most other countries.

### Swiss Health Care: Similar to Clinton Care?

It is not farfetched to see in the Swiss health system a close cousin of the Clinton health security plan although it is, of course, not an identical twin.<sup>18</sup>

Under the Clinton plan, households not covered by Medicare or Medicaid would have been mandated by law to pro-

vide for at least a mandated package of health benefits. Households would have made these purchases with the help of defined contributions from either employers or government and with their own funds if they desired relatively expensive coverage. The insurers would have offered households a variety of distinct policies for the mandated benefit package, notably, HMOs, preferred provider organizations, and traditional fee-for-service plans. The transactions between households and insurers would have taken place under a tightly regulated market structure called "managed competition." The competition would be managed by regional health care alliances, akin to farmers' markets for health insurance. These alliances would have assembled for households reliable information on (1) the premiums each plan would quote for the different types of policy covering a common, mandated comprehensive package of benefits, (2) consumer satisfaction ratings with competing health plans, and (3) objective information on the quality of the health care rendered by the network of health care professionals allied with each plan.

For their part, each private health insurer would have negotiated prices bilaterally with physicians, hospitals, and other providers of health care selected into the insurer's network. The insurers would also have exercised control over utilization of health care on the basis of clinical practice guidelines. The entire relationship between health insurers and the providers of health care was called managed care.

One could debate whether the Clinton plan would have been more or less regulatory than is the current Swiss health system.<sup>19-21</sup> For present purposes, it suffices to note that the Clinton plan would have achieved universal health insurance coverage, as does the Swiss health system, and that its envisioned workhorse for cost and quality control would have been consumer choice, albeit in a tightly regulated market for health insurance, just as it is in the current Swiss health system.

### Conclusion

Health services research seeking to test hypotheses on the basis of nonexperimental data frequently faces the problem that a given database can support 2 or more rival hypotheses. The Swiss health system is a case in point.

In the view of Herzlinger and Parsa-Parsi,<sup>3</sup> the Swiss health system provides empirical support for what is now known in the United States as consumer-directed health care. That approach expects insurance policies with high deductibles and coinsurance to convert hitherto excessively insured, passive recipients of health care into vigilant shoppers for health care, motivated to control both its cost and its quality and capable of doing so. Because Swiss households do bear relatively high out-of-pocket costs for both health insurance and health care, one can appreciate how this interpretation might be reached.

However, others might not be persuaded by this argument, for several reasons. First, across nations there ap-

pears to be no correlation between cost sharing and per capita health spending. Relative to Switzerland, Germany, the Netherlands, and Canada, for example, have much lower levels of cost sharing by patients but also much lower per capita spending on health care. Second, cost sharing by patients in Switzerland is unlikely to have begotten the allegedly superior quality of Swiss health care because, as Herzlinger and Parsa-Parsi point out, Swiss patients have virtually no information on the quality of the care they receive.

Finally, what is most impressive about the Swiss health system is the role tight government regulation plays throughout the entire system. One can plausibly argue that this regulation is chiefly responsible for both the high quality and (relative to the United States) low cost of Swiss health care. Absent that regulation, the Swiss health system probably would metamorphose into something resembling the much less regulated, high-cost US system, which is both more inefficient and more inequitable than the Swiss system, as Herzlinger and Parsa-Parsi take pains to point out.

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