Section 4. Management

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SWISS HEALTH CARE SYSTEM

Abstract. The article is devoted to the issues of the structure and structure of the Swiss healthcare system. The authors claim to see an analogy in the Swiss and American systems, the latter of which was developed by the Clinton administration.

Keywords: Basic insurance package, cost transparency, high-quality health care.

Intoduction. Of all the countries with universal health insurance, Switzerland has the most market-oriented healthcare system. The government accounts for a smaller percentage of total health care spending than the United States: 24.9% versus 44.7%.

The Swiss system is based on the principle of "managed competition," the same concept that underpinned the Clinton administration's 1993 health care reform plan and Mitt Romney's reform in Massachusetts.

Discussion. Under managed competition, the provision of medical services and health insurance are given into private hands, but the healthcare industry operates within a highly regulated "artificial" market. Swiss law requires all citizens to individually purchase a basic "package" of health insurance policies. Health insurance in the country is almost universal, covering an estimated 99.5% of citizens. Such law-abidingness is due to the national character of the Swiss. In the United States, where regulations are less readily enforced (even if they are for the benefit of the people), similar coverage rates would be unlikely to be achieved.

For example, in Switzerland, almost all car owners are subject to mandatory auto insurance, while in the US, only 83%. The concept of "basic insurance package" is not entirely true, since it includes a wide range of medical services – inpatient and outpatient treatment, care for the elderly, the disabled and the mentally ill, diagnostic examinations, maintenance in sanatoriums, prescription drugs, and even parallel or alternative types of treatment. Policies are purchased on an individual basis. Few employers provide employees with health insurance or pay part of the contributions. Private insurers provide policies.

There are currently 93 such companies, although not all have branches in every canton or region. Initially, there was a requirement that insurers operate on a non-profit basis, but in 2002 this restriction was lifted. Companies do not have the right to deny insurance to customers because of a health condition, and the amount of premiums is the same for everyone within a geographic region: healthy citizens actually subsidize the treatment of people with serious health problems. The only exception to this principle is for non-smokers, whose premiums are reduced by 20% compared to those who smoke.

In addition, according to a special formula, the volume of contributions is adjusted depending on the sex and age of the insured. Geographical variability is sometimes significant: depending on the canton, the difference in contributions can be up to 50%.

Insurance companies, unable to compete through risk management and "risk premiums" and forced to offer customers almost identical basic insurance coverage, compete with each other on price. Since they cannot reduce costs through risk management and insurance premiums, the pricing policy emphasizes differences in deductibles and customer equity.

The client can either buy an expensive policy with very low deductions and equity, or a cheap one where both components are much higher. The premiums vary, depending on the amount of equity and policy types: the cheapest costs $1.428 per year with $2.000 deductions, the most expensive is $2.388 with $250 deductions. Since employers do not pay for the health insurance of employees, all relevant costs are borne by the citizens themselves. As a result, many of them opt for policies with high deductions and equity. Because of this, the Swiss pay directly out of pocket up to 31.5% of total health care costs; this figure is twice that of the United States.

Recently, the system of "regulated" medical policies has been developing dynamically: like their American counterparts, they provide for lower premiums in exchange for limited access to specialist services and other types of medical care. Under policies, premiums are approximately $1.900 per year. The Swiss state provides low-income citizens with subsidies for the purchase of health insurance policies. Their size depends both on the level of income and on the assets available to the individual: the maximum possible allowance covers the average amount of the annual contribution for the canton where the citizen lives. The purpose of the subsidies is to ensure that health insurance costs do not exceed 10% of a citizen's total income. At the same time, the state does not pay the full cost of health insurance, so as not to create incentives for those receiving subsidies to choose the most expensive policies with the lowest levels of deductibility and equity. About a third of Swiss citizens receive subsidies in various forms, 19% of the total insurance premiums are paid from public funds.

In order to negotiate compensation with health care providers, Swiss insurers form cantonal-scale cartels. Providers are obliged to limit themselves to the agreed amounts: additional billing is prohibited. If insurers and providers cannot agree on rates, the cantonal authorities have the necessary powers to intervene and force the parties to reach an agreement. However, there are no geographical restrictions on the practice of doctors, so providers can "vote with their feet", moving to a canton that offers them higher fees – this leads to a shortage of doctors in some parts of the country. The system of medical institutions includes both public and private hospitals. The private sector makes similar fee arrangements with insurance cartels and doctors. The state ones are subordinate to the cantonal authorities, which, accordingly, negotiate with insurers and provide subsidies to hospitals.

In some cantons, people who have bought only the basic insurance package can only go to public hospitals; access to private medical facilities requires the purchase of additional policies (see below). Recently, some providers have begun to operate outside of the agreed rates. A market for supplementary insurance is beginning to emerge in the country to cover the cost of treatment from providers who are perceived to provide better services or the most advanced treatments. Supplementary insurance provides access to private hospitals in cantons where it is not available with the basic package. When treated in public hospitals, additional insurance can pay for services such as the provision of a separate room 54 53 that the basic package does not cover. According to some estimates, today up to 40% of citizens already have additional insurance policies. Switzerland does not have a single state budget for health care, so it manages to avoid the waiting lists for medical care that are typical of other countries' health systems.

In addition, Swiss medicine is distinguished by a high degree of equipment with modern medical technologies, which, however, is not cheap. Health care spending is 11.5% of GDP, second only to the

United States. Since consumers of medical services bear the price costs of their decisions, there is reason to believe that such a "exchange" of quality for money corresponds to the desires of patients. They choose quality medical care, despite the fact that for them personally it will result in additional costs.

Since medical services are considered by economists to be a "normal commodity" – that is, their consumption grows along with people's incomes – Switzerland is among the wealthy countries, such a choice seems absolutely logical. The share of healthcare spending in relation to GDP is still lower than in the United States, with a comparable quality of services provided. The data clearly show that Swiss personal financial responsibility for their own health care decisions makes them smart consumers, helping to contain overall health care costs.

Regina Herzlinger and Ramin Parsa-Parsi of Harvard conclude: "The fact that the health care spending situation in Switzerland is manageable is likely due to the significant role of consumers in paying, resulting in cost transparency." The transparency of the system determines the sensitivity of its response to consumer preferences.

The Swiss seem to be happy with their healthcare system. This year, voters voted overwhelmingly 71% in a national referendum to reject a proposal to replace it with a single-payer scheme. The Swiss system is not without its shortcomings associated with the predictable growth of compulsory insurance and government regulation, which is by definition present in any scheme based on managed competition. In most markets, consumers enforce price discipline by simply refusing to purchase a product that is too expensive. Mandatory health insurance deprives them of this leverage since consumers must purchase this "product", even considering its price too high.

This is exactly what is happening in Switzerland, and the consequence of this development is a steady expansion of the basic insurance package. In particular, the Blue Front, a powerful lobbying coalition of physicians and hospital management, has achieved a significant expansion of covered services in exchange for relaxing the "free choice of provider" legal provision, making it possible to enter into "managed contracts" with providers. The expansion of coverage leads to higher costs for insurers, only partly offset by higher deductibles. While the proportion of health care spending that consumers pay directly out of pocket remains high, it has fallen by 10% over the past decade. Moreover, the expansion of coverage translates into higher costs for the system as a whole, since the Swiss bear the costs of their own decisions regarding health care to a lesser extent. If this trend continues, it could undermine the cost transparency that is the hallmark of the health system.

Uwe Reinhardt notes in this regard: "Over time, the expansion of compulsory insurance coverage absorbs an increasing share of the payments that fall on the shoulders of consumers, thereby diluting the decisive role that they play in the Swiss system." Evidence suggests that the provision on the uniform nature of contributions within regions creates distortions in the market for medical services, turning them into "overproduction" for the healthy and a shortage for the sick. The ban on risk management for insurers hinders the introduction of new, innovative products.

Peter Zweifel (a member of the Swiss Competition Committee, which regulates the insurance industry) from the University of Zurich believes that a return to the practice of "risk ratings" can ensure the effectiveness of the health care system in the long term. "Let competition play its magic," he said. Let those who lead a risky lifestyle understand that they need to change it.–10% of taxable income.

A number of distortions are also introduced by the practice of creating cartels to negotiate providers' fees. In fact, cartels have a buying monopsony, and therefore a huge influence on the outcome of negotiations. Not surprisingly, practitioners prefer to work in cantons where they are offered the highest level of compensation, leading to a shortage of doctors in other regions. This pricing structure is reported to create incentives for misallocation of resources,

such as hospitals moving patients from outpatient to inpatient care.

In addition, the combination of growing demand with low prices for some types of medical services leads to the appearance of the first queues – for the most complex surgeries. In addition, such negotiations perpetuate a price system that prevents the development of innovative approaches in which it does not tie payments to specific components of insurance coverage. We are talking about both "managed care" and integrating health services. Finally, one of the most stringent systems in Europe for regulating the activities of representatives of non-medical professions operates here.

Conclusion:

As a result, it often forced patients to turn to expensive providers, although it could dispense the services of less highly paid specialists. The combination of these factors undermines the decisive role of the consumer in health care. However, despite these problems, the Swiss experience can be useful for the United States – it contains valuable lessons about the virtues of medicine, in which the consumer plays the first fiddle. We see, in particular, that when the cost of insurance becomes more transparent, the consumer prefers "genuine" insurance (which distributes catastrophic risks as widely as possible) rather than purchasing routine, inexpensive services prepaid. As a result, there is a general incentive for consumers to make value-for-money decisions when purchasing health services, leading to cost reductions while maintaining individual choice and high-quality health care.

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