REGULATION, CARTELS, QUALITY AND CHOICE : AN UNSUSTAINABLE SWISS MIX

Alphonse Crespo MD*

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Introduction

Switzerland's social security system rests on private initiative, employer mandates and government subsidy. Its original design left a substantial place to individual responsibility and competition while empowering government with the tasks of safeguarding public health and guaranteeing basic provision for disability and old age.

The Swiss three-pillar model is particularly well defined in legal and institutional frameworks that govern pensions. The three tiered provision for retirement relies on: i) a public old age pension scheme that guarantees all citizens a minimal revenue after formal retirement age (65 for men, 64 for women); ii) a mandatory employer-based "second pillar" for salaried workers, that provides pensions funded by salary deductions and employer contributions; iii) Optional tax-deductible specific savings accounts and long term life insurance capitalization schemes constitute the third pillar. The second and third pillars - covered by more than 4000 corporate pension funds and competing banking or insurance products - were prudently installed to complement the first (public) pillar threatened by predictable deficits. However uncertainties regarding the long term sustainability of the second mandatory pillar have surfaced in the last few years. Citizens will vote in March 2010 on a readjustment of second pillar entitlements designed to safeguard reserves and ensure sustainability. The issue of the vote remains uncertain. Incidentally, the Swiss will vote on the same day, on the rights of animals to have lawyers!

Though primarily designed for pensions, the three-pillar principle also guided the provision of health services. Until the mid 20th Century, Swiss health care benefited from an efficient institutional framework that offered a balanced blend of individual consumer choice, provider competition and government intervention. In past decades, political consensus on the respective place of government, private economy and individual initiative in health care changed. Successive constitutional amendments, legislative reforms and government decrees gradually nudged free market and individual responsibility out of the main frame. Ideological groups, lobbies and bureaucracies (i.e. the real state) are now the dominant forces that control regulation and provision of health services at all levels. Compared to other systems, Swiss health care still rates well and some of its specificities do indeed deserve praise. However lessons can be learned from the circumstances that brought quality downgrades and restriction of choice into what was once an almost perfect health care system.

Historical overview

Swiss social security systems are rooted in 19th Century constitutional reforms adopted in the aftermath of Switzerland's 1847 civil and religious Sonderbund war of Secession. These reforms

were partly deemed to soothe the wounds opened by this short military confrontation between catholic and protestant Cantons; they also trumpeted Switzerland's move towards stronger central federal authority that the defeated Sonderbund secessionist cantons had unsuccessfully attempted to oppose.
The "blood and iron" consumed in any modern state's military endeavors, needs redemptive institutional liniments. Bismarck the Prussian warrior, father of modern wars and forerunner of Nazism, invented modern social security. Truman the haberdasher - whose feats in Hiroshima and Nagasaki set humanity's all time records for civilians killed or maimed by soldiers in a single second - laid the ground for Medicare and Medicaid; a napalm happy binge in Vietnam offered Lyndon Johnson the the adjuvant needed to complete the task. Would the British NHS have seen the light without Churchill's "blood and tears" that seeded Bevan and Beveridges' paternalistic monster? Would Obama be desperate for health care reforms without the call for an expiatory counterpoint to his country's painful Afghan and Irakian crusades?
The Swiss federal government's march into health care started shortly after the Sonderbund civil war, with the creation of military insurance & pension funds. These limited schemes aimed at maimed soldiers, were instituted in 1852; premiums and benefits depended on family situation, wealth and income. By 1895 however, military insurance had grown into a comprehensive national health and accident military institution fully funded and managed by the federal state. It covered treatment and compensation for all accidents and ailments incurred by soldier-citizens during their federal military service irrespective of their wealth or income. Federal Military Insurance remains to this day the most generous entity in Switzerland's insurance spectrum. An attempt to expand the military insurance model to civilian society was sharply rejected by a referendum vote in 1900. It took another decade and World War I before the first federal sickness and accident insurance law (LAMA) was accepted and implemented. LAMA confirmed that federal authority was now ready to take up missions governing any or all aspects of civilian life.
Switzerland's social insurance system was partly influenced by Bismarck's blueprints for social security. However, the specificities of the Swiss version highlight the subtle cultural divide that separates Switzerland's unique attachment to citizen sovereignty and decentralized government from the addiction to obedience and military discipline then rampant north of the Rhine. LAMA established the fundamental principle that was to guide health care provision, regulation and funding: namely that of the subsidiary role of the State. The government's task was not to provide health care but to ensure that all citizens had access to health services.
The practical implementation of this objective was delegated to the Cantons; they accomplished this by subsidizing sickness insurance funds or, - after implementation of mandatory insurance in 1996 - by targeted subsidies to income groups unable to fully pay their insurance premiums. They also contribute to the funding of hospitals on a strict 50-50 "dual" basis. Proposals to reduce and fine-tune government subsidies to hospitals are currently discussed by federal parliament. This will not affect the Cantons power to centrally plan public hospital networks and regulate their provision of care.

The effects of regulation on Swiss medicine

In health care as in the organization of the police forces or of education, the Swiss federal Constitution grants wide autonomy to the Cantons. The mission of guaranteeing access to medical care for all income groups was originally achieved though cantonal subsidies to mutual sickness funds and public social assistance services for the severely indigent: the latter however,

represented only a marginal segment in a thrifty nation spared from massive destruction of wealth inflicted by two world wars on its belligerent neighbors.
Switzerland's political culture promoted fruitful coexistence between private and public health services. Tensions between the proponents of socialist reform and market friendly conservatives were softened by the"compromise and consensus" principle ingrained in Swiss political tradition. For decades private insurance and private hospitals were allowed to work and prosper within relatively unobtrusive regulatory guidelines. Medical infrastructures were comparable to those of other advanced nations while the decentralized constitution of the country and an efficient insurance model probably ensured easier and faster access to "state of the art" care than was the case in major industrialized European nations.

A strong local pharmaceutical industry that counts giants such as Novartis and Roche brought significant contributions to therapeutic progress. Manufacturers also worked closely with physicians and with teaching hospitals. Innovative therapeutic substances were readily available to the Swiss. The pharmaceutical sector also was and remains one of the key contributors to Switzerland's positive export balance. As such, it was long spared from intrusive political interference. With the surge of environmental extremism that has also infiltrated the Swiss scene, the days of a health-industry friendly parliament are probably over. Whereas environmentalist hostility targets the "chemical" nature of manufactured therapeutic agents, health insurance lobbies primarily portray pharmaceutical products as a source of expenses. They do not see them as tools for better health or cure. In Switzerland as elsewhere discriminatory regulation designed to discourage prescription of original drugs has gained ground. This is pushing innovative industry towards the easier, more lucrative and politically correct production of quality generics, probably at the expense of research and development of new curative substances. The impact of this trend on future medical progress and therapeutic innovation is evident.

The Swiss mountains are not only reputed for their ski resorts. They also harbour sanatoriums haunted by the ghosts of famous ailing itinerant romantic figures in quest for dedicated doctors, oxygen and cure. The discrete luxury of many Swiss private clinics still attracts statesmen and celebrities from neighboring countries and beyond. Some Swiss, however have begun to find their way to the US for second opinions or for complex and costly treatments that domestic doctors are reluctant to prescribe through fear of reprimand from their insurance overseers. The Swiss sickness insurance model does not appreciate "expensive treatments". The myth of "evidence-based" medicine and the perception that a proposed diagnosis is a reliable indicator of what every treatment should cost, now gives administrations powerful pseudo-scientific tools that they can use on a wide scale in order to regulate, restrict and ration medical treatment.

Sickness insurance insurers now closely track doctors' activity. They identify physicians with over average fee and prescription profiles and threaten them with claims for repayment of fees and costs of treatments. Dedicated practitioners who treat higher numbers of elderly or chronically ill patients are particularly vulnerable here; there are instances where they have been literally wrecked by litigation for preposterous reimbursement claims initiated by sickness insurance administrations. Some wary general practitioners now avoid prescribing diagnostic procedures considered expensive and that might affect their "cost profile", such as MRI scans. Delays in diagnosis linked to such timidity not only hurt patients but ultimately impact on global

health care expenses. As every surgeon knows, a stitch in time saves nine. Sickness fund watchdogs see things differently.

There are exceptions. SUVA, the major Swiss accident insurance fund, is not only mandated to cover costs of treatments but also has to grant loss of salary compensations and disability pensions after injury. This leads SUVA to consider timely diagnosis, state of the art treatment and sophisticated rehabilitative care as means of limiting post injury sequels and the far costlier compensations and disability pensions that follow. This policy has enabled SUVA to bring disability pension costs down by close to 45% between 2003 and 2009 according to a recent press release. However SUVA is not immune from cartel pressures: it is preparing to align its balanced medication reimbursement policies to the restrictive administrative practices of the sickness funds.

Technological progress, market and ideology

Major technological advances in the second half of the 20th century have radically changed medical, industrial and even cultural paradigms. They have also put health economies at test. In health care as in other fields, radically innovative products are costly when they first hit the market. In a free market economy, prices of successful innovative products diminish when development costs are covered by sales, when productivity expands and when competition sets in.

Pharmaceutical innovation, complex diagnostic tools, new technical devices widen the range and efficiency of medical services; this naturally brings civilized societies to direct more resources towards health care. Technological breakthroughs also accelerate the flow of medical information. Patients today are more knowledgeable and more demanding than those of preceding generations: they are aware of what state of the art medicine can give and are increasingly becoming able to assess if they are offered the best available treatment. External factors such as higher life expectancy and migratory changes also contribute to the growing part of GDP allotted by advanced countries to health care. Unfortunately market mechanisms have not been allowed to work for health care in the same way as in sectors such as computers, air travel or telecommunications. This has created a rift between medical progress and institutional frameworks.

The revolution in medical technology that radically changed medicine in the 20th Century, coincided, in continental Europe, with the upsurge of Statist ideologies. Through the second part of the 20th Century, collectivistim found advocates far beyond Soviet captive nations. The influence of socialist dogmas on European public policies culminated in the 70's. The advent of Margaret Thatcher and Ronald Reagan was instrumental to their decline and the crumbling of the Berlin wall would unequivocally expose their failure. This did not stop socialism's paternalistic redistributive dogmatism from contaminating Swiss health care. Swiss policy makers from all boards came to believe that rising health costs and equitable provision of medical services

imperatively needed stronger redistributive and regulatory tools. No attempt was made to examine the dynamics of health care from a free market perspective. Reigning ideologies hammered that "health care could not be left to the market"; the more extreme claimed that the "right to health care" meant that patients should never have to pay for medical services and that the state should provide them for free.

Such rhetoric found sympathetic echoes within the medical corporation. Physicians were generally only too happy to showcase the noble generosity of their mission by taking the money question out of their interaction with patients. They may have also assessed that entrusting their bills to what appeared to be highly solvable third parties, would ensure flawless payment. They dismissed the old adage that he who pays the piper calls the tune. They also overlooked the fact that by choosing a paymaster other than their patient they would ultimately be called to compromise with the core ethical principle of their mission that calls them to treat their patients to the best of their ability.
Swiss social-democratic pied pipers were able to push a revised sickness insurance law (LAMal) that met little resistance from physicians. Promises were made that the new legislation would stop health insurance premiums from rising. This law was ultimately accepted by popular vote in 1994 and formally implemented in 1996. The most significant change was the introduction of mandatory sickness insurance and the expansion of the federal state's regulatory powers. Mandatory insurance rapidly established insurance cartels as a major force in Swiss health policy making. It also disrupted mechanisms that ensure a dynamic equilibrium between offer and demand and that enable consumers to influence prices in competitive markets. Co-payments and deductibles offered only limited place for direct consumer involvement in health service cost equations.

Switzerland became prey to known inflationary cycles that inevitably appear wherever third party payment edges consumer control out of transactions and whenever corporate interests, lobbies and ideological rhetoric influence public policy. The progress of medicine from affordable palliative treatments to more ambitious curative objectives came with a price tag. Rising health costs partly shrouded by third party payment and public subsidy gradually disconnected large segments of Swiss health care provision from market reality. Some attempts were made to meet spiraling costs through regulation, price controls, restrictions of new medical practices and rationing of hospital beds. This did not affect the rise of insurance premiums that captive citizens had to pay year after year.

Mandatory insurance premiums presently cover 35 % of expenditures. Taxes finance approximately 25%. Supplementary insurance and contributions from private institutions account for 10%. The rest is met by out of pocket payments and deductibles that range from CHF 300 to 2’500 per year. Patients pay for 10% of ambulatory care. Insurers called on parliament to raise this to 20%. Co-payments for original drugs have already been propped to 20% when “equivalent generics” are available. In Switzerland as elsewhere, however, citizens ultimately end up paying for the full bill of the regulated health piper through taxes, premiums, co-payments or deductibles while it is insurers who call the tune.

Individuals pay the full cost of premiums, but lower income groups are able to apply for Cantonal subsidies to help cover their premiums. Individuals are also able to purchase supplemental insurance to cover the higher fees of private hospital services or therapies that are not covered by

basic insurance. Over 30% of Swiss citizens purchased supplemental insurance. Mandatory accident insurance for salaried workers is purchased by employers, as is the case for insurance for occupational diseases. Some corporations also contribute to their employees' sickness insurance premiums.

SUVA, the major Swiss national accident insurance fund, holds a monopoly over the secondary sector (industry and trade) and also insures the unemployed. Private insurers predominantly cover primary (agriculture) and tertiary (services) sectors. Their influence in parliament has so far have so far enabled them to parry SUVA's attempts to extend into their domain. Primary and tertiary sectors are free to choose their accident insurer.

The "basic benefits package"defined by parliament that all sickness insurances are mandated to offer, and is constantly subject to revisions. The political decision making processes that guide such revisions is tied to consultations and negotiations with major stakeholders and is very vulnerable to pressures from the more powerful special interest groups. Cost-cutting agendas in health care as well as increases in premiums seldom face significant resistance within federal policy-making circles.

To be fair and despite cartel dominance, the Swiss insurance system does allow some room for competition between insurance providers; compared to other European models it offers consumers at least an illusion of choice. Individuals are free to choose their insurance company or to change their basic insurance provider without penalty. Insurers are not allowed to deny basic coverage on the ground of pre-existing conditions. However the regulated competition offered by a well oiled insurance cartel, has not curbed the up hill course of insurance premiums. Neither has it improved quality. When the prices of goods or services are fixed by decree or by cartel agreements in pseudo-competitive markets, some competitors might be tempted to gain customers by offering better quality for equivalent prices. This has not been the case for medical care.

Hitting hospitals and physicians

Public hospitals were the first to be hit by cost containment policies triggered by 1994 health insurance reforms. Between 1998 and 2000 the number of public hospital beds was slammed down by 6% through forced mergers of regional hospitals, closing of acute care units, centralizing of heavier technology and rationing of nursing care.

Downgrading of local hospitals created inequities in access to centralized specialized units and sophisticated medical technology. Patients from small towns or more remote Alpine valleys run the risk of being bounced from one local hospital to another before receiving appropriate care. Ambulances (and even helicopters) come to replace elevators as a routine means of transfer from one specialty unit to another: expenses have been transferred from care to carrier without diminishing total costs.

Regulators targeted average lengths for hospital in-patient care. These have been cut from 12.9 days in 2000 to 9 days in 2004. Reimbursement scales encourage outpatient surgery despite higher risks and lower patient comfort. Low fees for demanding procedures (linked to longer

stays in hospital) dissuade surgeons from performing heavy elective surgery. Waiting lists have become the rule in University hospitals. Complications in larger hospitals, linked to medical errors, hospital infections and premature dismissals have become a cause of public concern. Worrisome rates of "critical incidents" at the university hospitals of Geneva and Lausanne were reported by a scathing survey published in 2007[1]. Headlines on hospital errors that haunt French public hospitals, no longer spare Switzerland. The death shortly after Christmas 2008, of a 4-year old girl promptly dismissed from Aarau Canton Hospital by an overworked staff, without a routine blood test that could have detected the treatable cause of her fever, caused a public outcry.

This has not stopped federal health policy makers from calling for more drastic cuts in the number of hospitals. In the year 2000, an OCDE study ended to demonstrate that waiting lists for care did not exist in Switzerland. This is no longer the case as Professor Hoffmeyer, president of the Swiss Orthopedic Society points out in December 2009[2]. Fortunately More than 40% of the Swiss choose to buy some form of complementary insurance. The private hospital sector, open to patients with supplementary insurance, has grown both in terms of quality equipment as in number of available beds. Fortunately the rift between private and public establishments has narrowed. Whereas in the past, private clinics would leave the difficult cases to university hospitals, this is no longer so. The private sector's greater flexibility has enabled it to invest in new technologies without administrative delays or bureaucratic hassles. In order to avoid waiting lists in potentially life-threatening situations, some public hospitals now sub-contract with neighboring private establishments for specific treatments such as non-invasive cardiology procedures.

Health care accounted for 3.5% of Swiss GDP in 1950 and has reached approximately 12% today. We are far from the "explosion of costs" that public policy decision makers agitate in order to push harsh regulation and rationing measures. Only those directly concerned by health care, i.e. doctors and patients, realize that sums paid for health services are in fact investments directed towards the improvement of health. Little is said of the productive jobs that a blooming health care sector creates. Public financing and regulation of health care is governed by complex and obscure redistributive agendas. Patients are rarely strong political constituencies: bed-ridden victims of serious illnesses seldom vote. Policy makers are quick to present health care as a sector where every penny spent is a penny lost. Rationing of medical and nursing care services comes more naturally to administrators than hitting at the non-productive administrative costs entailed by regulation. As Basel based Dr Roland de Roche, editor in chief of *FMCH-Direct* the Swiss Federation of Surgeons' quarterly, reports[3]: the Basel University hospital budgeted 48.5 new administrative posts for 2010 in order to manage DRG-based coverage of stationary care. Increases in administrative resources generally go in parallel with a decrease in the number of hospital beds, of nurses and of doctors.

Past generations of Swiss physicians were able to practice their art within a contractual frame that made them accountable only to their patient. The emergence of third parties brought along a growing tribute to administrative paperwork. The growth of regulatory hassles took an exponential turn with the sickness insurance reforms implemented in 1996. These reforms called for permanent interaction and consultation between representatives of doctors, insurers and the state. They also significantly strengthened the authority of public health administrations and gave legitimacy to coercive central planning processes targeting medical practice.

Some of the legislative and administrative constraints doctors presently have to face were self-inflicted. In 2004, after protracted negotiations, insurers and the Swiss doctors' federation agreed to implement a fee scale (TARMED) - originally championed by physician representatives - designed to reward the time "intellectual services" rather than technical performances. The "neutrality of costs" clause included in the agreement implied that upgrades for basic consultation fee scales, would have to be balanced by reduction of tariffs for surgical procedures, X-rays, imaging, lab tests and other "non-intellectual" aspects of medical practice. TARMED also brought about tighter controls of doctor billing and prescriptions. Facets of medical activity such as the duration of consultations, the daily number of visits or average costs of prescriptions are now tightly monitored. This has increased doctors' administrative paperwork taking time and energy away from patients.

Switzerland counts approximately 25'000 doctors, 55% in private practice. In 2002, on the assumption that health costs depend on the number of practicing physicians, federal government introduced a ban on new private medical offices. This decree supported by the insurance lobby, circumvented constitutional rights governing freedom of industry and commerce. The Swiss Federation of Doctors did not protest strongly. This association reflects the voice of established doctors. The ban on new practices clearly protected existing practices from the competition of newcomers. Cantons were ultimately constrained to introduce loopholes in order to parry a looming shortage of GPs particularly in small towns and rural areas. Despite proposals to ease this ban from representatives of Cantonal health directors mildly backed by the Swiss Federation of Doctors, federal government recently chose to extend it until 2011. As was to be expected, patients have learnt to circumvent the growing scarcity of private practitioners by using emergency and outpatient departments of acute care hospitals as primary care providers. Regulatory measures designed to constrict "medical demography" are now targeting physician resources of outpatient sectors in public hospitals.

Cost-containment remains a top priority for Swiss health care policy makers. Putting the onus on patients as was attempted at one point, brought no clear dividends. Health insurance cartels and their political proxies find it more convenient to keep the pressure on medical professionals generally more prone to compromise than patient defense groups and tort lawyers. Swiss physicians have accepted the role of scapegoats for the last twenty years and this is affecting their morale.

An extensive survey on perceptions of trends in health care and their profession conducted among European doctors in 2004 demonstrated that one Swiss doctor out of two sensed a decline in professional status over the last 10 years and that one out of three foresaw a decline both in his future role in the health care system and in his satisfaction with his practice. Only one out of ten doctors expected his satisfaction and his position in the health care system to improve in the future. Close to 30% of Swiss doctors predicted that the quality of health care available to the average family would decline in the future, while only 19% thought that it might improve.

Excessive regulatory measures reached a turning point when physicians unveiled their frustrations in an unprecedented demonstration in Bern in 2006. On April 1st that year, approximately 12,000 Swiss medical practitioners backed by a petition signed by 30'000 patients protested in the federal capital against the dismantlement of basic family doctor medicine and of

house-medical services. Although federal health policy makers pooh-poohed the doctors' march, this event marked the dawn of pseudo-consensus and of unilateral compromises between medical professionals and political authority.

Pascal Couchepin, then at the head of the federal health care department sparked further unrest in 2008. This former president of Switzerland who had worked closely to the insurance sector during his professional career, decreed, that cartel insurers would be entitled to slash lab-test reimbursements by approximately 20%. This controversial move was designed to ration lab testing by pushing general practitioners to give up their labs with the predictable consequences of slowing down access to diagnosis and impacting on the already over strained work load of public hospital laboratories. The result was a doctor protest strike followed by demonstrations in various cantons in Spring 2009.

Current Political Roadmaps

Despite repeated regulatory measures designed to cut costs, insurers claim year after year that basic health care package premiums does not meet their expenses. This trend was confirmed in 2009. According to recent releases from "Santé-Suisse", the organization that speaks for Switzerland's health insurance cartel, global health care expenses (including dentistry) reached CHF 60 billion. (i.e ±40 billion Euros) of which CHF 31.6 billions were covered LAMal basic insurance schemes . Approximately 30% of these costs were met by premiums, 6% by patient co-payments and deductibles, while Cantons' contributions amounted to 12% Santé Suisse claims that this leaves insurers with a deficit of CH 800 millions that had to be ploughed out of insurance reserve funds. Little mention was made of the significant impact on insurance reserves caused by the explosion of financial bubbles that marked 2009: an undisclosed part of reserve funds invested in volatile Madoff-type lures probably weighed significantly on bottom lines. As was to be expected health insurers announced in 2009 that their reserve funds would not be able to meet minimum legal requirements without major premium hikes in 2010.

This sparked a set of federal government propositions for further "urgent" measures designed to reduce costs at the rate of CHF 240 million a year. A "moderating ticket" championed by former federal Social Affairs minister Pascal Couchepin, that would have had patients pay a CHF 30.00 tax for each visit to a doctor was not approved by parliament. Other proposals to increase patient co-payments are currently under discussion.

Compared to other western industrial countries, Switzerland was rated second only to the US with regards to ability of patients to choose their physician. A law voted by parliament that would have given full power to insurers to choose the doctors entitled to treat their patients was rejected by a citizen's referendum vote in June 2008. This has not stopped parliament from studying legal incentives for the expansion of managed care models. The project of making such models mandatory for basic insurance packages has not been discarded. Managed care models allow a greater scope for regulation and rationing. They also imply restrictions of patients' freedom to choose their doctor.

In 2007 Swiss citizens massively rejected the Socialist referendum proposing a single national health insurance provider. Yet the project, supported by prominent members of parliament,

resurfaced in 2009. This is but one example of the cleavage between political "elites" and voting citizens that plagues even "perfect democracies".

The regulatory process that led to bans on medical practices, rationing of hospital beds and strikes at diagnostic tools, was mainly pushed by Santé-Suisse, the powerful cartel spawned by mandatory health insurance voted in 1994. Letting aside its morally questionable coercive essence, mandatory insurance ultimately damaged Swiss medical care without diminishing costs. Indicators on European systems signal the decline of Swiss health care. Long ranked amongst the top four in world health care, Switzerland sunk to 8th position as the 2008 *Euro Health Consumer Index*[4] shows and now lags behind countries such as Holland, Austria or Luxembourg. On the other hand, total health expenditures, 11.3 % of GDP in 2006, remain well above the OECD average of 8.9%.
To be fair, some parliamentarians and not necessarily from conservative circles, have tried to react against the control of health legislation by lobbies and cartels. Armed with a legal study from Professors Kägi-Diener and Rhinow, socialist MP Jacqueline Fehr formally questioned the influence of sickness fund representatives on health lawmaking and regulation. Her quixotic proposal to bar mandatory insurance officials from key legislative commissions was not followed by the Swiss federal parliament. The defeat of Jacqueline Fehr demonstrates beyond doubt the power of a sickness insurance lobby that rules across party lines.

Dynamics of change

How can liberty-oriented policy make the case for private insurance, competition and free choice in health care? The famed Chilean reforms that sparked the global drive towards privatization of pension systems show how public retirement plans can be successfully transferred to the private sector. Switzerland's "third pillar" private pension plan option could easily be extrapolated to health care provision. Tax credits or tax exemptions would seed-fund health banking accounts and stimulate a return to the actuarial mission of insurance. By saving for future health expenses when they are young, individuals would ensure that they are able to decide how their health capital will be used when they need it. This is not the case today: individual pay for health care through taxes and premiums, but others decide when, how and if they will get care.

Medical savings accounts were gaining ground in the US where legislation introduced by the past Republican administration allows citizens to transfer sums from their Individual Retirement Arrangements (IRA) into Health Savings Accounts (HSAs) provided that they are backed by high deductible health insurance plans. Policies promoted by Obama threaten the HSA model in two ways. Mandatory health insurance with first dollar coverage or a best, token co-payments will make health savings accounts appear redundant thus creating a disincentive to save for future health needs. A deadlier threat comes from irresponsible deficit spending and money printing policies that not only threaten existing wealth but that will inevitably spark spirals likely to wash out the value of present and future bank savings accounts.

Citizens of Singapore have benefited from HSAs (Medisave) complemented by social insurance for catastrophic illness since 1984. They now probably enjoy one of the most cost effective and accessible quality high tech care in the world. The Singaporean success story has inspired other countries in South East Asia. Pilot experiments in urban health care financing through compulsory savings accounts have been carried out in China since 1994: these will predictably

open the way to less coercive models and will expand exponentially as was the case with other Chinese capitalist experiments in the past.

Other countries such as Georgia or Slovakia have turned their backs on sovietized health care gulags by implementing far reaching privatization programs. Incremental moves towards market-oriented health care are also changing the substance of socialized medicine in Scandinavia or in the Netherlands. After a physician Jacques Chaoulli made a federal court appeal against the legal ban on private hospitals in Quebec and won, even Canada has had to confront the blatant contradiction between constitutional guarantees and institutional constriction of access to timely care spawned by "universal health services". The problem with Swiss health care's downhill slope, might be that it started from a higher ground and may take more time to hit the bottom.

Conclusion

Implementation of market reforms for health care in Switzerland as elsewhere still faces a number of hurdles. In former Soviet Europe, medical black markets allowed consumer mindsets to survive "underground". Patients who preferred real and timely care to "free" care were accustomed to pay their doctor cash and under the table. Such mindsets have probably made it easier for policy makers in former Communist countries to privatize medical services and radically move to open markets in health care.

Conversely citizens in countries such as Switzerland, have come to take it for granted that third parties will always pay for part or all of their health care needs. Although individuals always end up paying for their care, either through taxes or premiums, the regulatory and redistributive action of government and the dominant position of insurers disconnects the real payers from decision-making processes. Market mechanisms no longer work in favor of the consumer. Patient-centered medicine disappears. Eventually increases in premiums and taxes make it harder for patients to pay for routine care out of their pockets or to save money for future expenses. This furthers their dependency on third parties.

Swiss direct democracy gives citizens the last word on most political concoctions. This enabled voters to check demagogic moves towards a single public insurance provider proposed by socialists, or towards further limitations to patient's liberty to choose their physicians pushed by insurers. On the other hand, democratic proposals towards market oriented and patient centered care are vulnerable to dialectics and to emotional rhetoric. Furthermore, leaving ultimate decisions to majorities does not guarantee that patient interests will triumph. Although practically every single living human being will be a patient one day, patients even if they are strong enough to vote, will always represent a minority. Their vote counts for little and politicians know it.

Bismarck, Bevan and Beverige are dead and buried. Unsustainable European social security systems fathered by obsolete ideologies make take time to hit the "dustbin of history". The “winds of history” will sooner or later move health care back to the market as they have done with airlines, with communications and with pensions. Free-market intellectuals and enlightened politicians will eventually succeed in adapting legal frameworks governing health care to new paradigms. In free societies however, thoughtful individuals need not wait for legislative change before making their own decisions on how they will manage their health. They can start with

simple moves such as saving for illness, privately insuring against risk and if they can afford it, crossing borders to find the best available care when they can't find it in their own land.

Wealthy foreign patients ready to pay cash for care in Swiss posh private clinics may sometimes be treated harshly by zealous Geneva cops as was the case for Khadafi's 8-month pregnant daughter in law on July 15th 2008. They will never be put on a queue for diagnosis and appropriate treatment. Switzerland however has to face serious competition in this niche market. Houston and Cleveland have taken over as undisputed world centers for medical excellence. Further East, Singapore, whose outstanding health care system is founded on free markets and health banking, offers antidotes to rationed medical technology. It has become a major hub for health tourists from countries plagued by universal health services. Patients threatened by regulated organ shortages and willing to pay a donor for his services, might find lifesaving alternatives in China, in Bombay or even in Bolivia. As is the now case for production of cars, computer technology or manufacture of perfumes, high tech medical care is no longer bound by borders.

Switzerland still offers cues as to how to climb out of regulated health care quagmires. The Swiss third pillar pension model shows how market can supplement and ultimately replace unsustainable public plans. Health savings accounts (HSA's) replicate this model in health care. Health savings capitals restore individual responsibility, patient empowerment and patient-centered medical service. By coupling HSAs with high deductible catastrophic insurance, individuals cover both risk and predictable ailments that come with age. Targeted mandatory insurance as existed in some Swiss Cantons before 1984 would also reduce the power of insurance cartels without depriving lower income groups from basic health care coverage.

Medical tourism will increasingly allow certain categories of patients to find their way to cure but will not solve all problems. International competition between health care systems however does exist. It can help enlightened policy-makers look beyond their boarders and hopefully lead them to learn from medical havens such as those of America before Barak Obama, of Singapore today and who knows, of tomorrow's China.

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[*] *Orthopedic surgeon & author. Founder and executive director of* Medicine & Liberty*, network of liberty oriented physicians.*