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The Decline of Social Insurance in Modern Healthcare

Lessons from Switzerland and beyond

By Dr Alphonse Crespo[1]

Abstract

Many envy Switzerland's pluralist health care insurance model. The subsidiary role set for the State and a long Swiss tradition of political consensus fostered fruitful coexistence between subsidized social security and private insurance and health care services. This ensured accessibility, quality and choice in medical services for many decades.

Health insurance laws implemented in 1994 altered a delicate balance between power and market by endowing state bureaucracies and insurance cartels with extensive regulatory powers. Citizens rapidly paid a price not only in terms of costs and of quality of care, but also in terms of freedoms lost. In March 2007, dissatisfied Swiss voters massively rejected an initiative for a single social health insurance provider. This first signal was followed in June this year by the rejection by the people of another initiative that would have increased the regulatory power of the insurance cartel. Competing proposals from the insurance sector and from doctor unions are presently on the floor: policy makers are however not ready to examine radical reform of a system and focus on short term solutions aimed exclusively at cost control .

New models that combine high deductible risk insurance with health savings accounts are being implemented in countries as different as Singapore, the USA, or South Africa. They open the way to diversified insurance services and to health banking products that will not only meet the stakes and needs and of modern societies but that will also restore liberty and responsibility in health care.Transition costs of devolution of health care to the market can be minimized through policies aimed at rapid deregulation of insurance services and privatization of health care infrastructures. Fiscal incentives (tax credits, tax exemptions) can also facilitate the growth of health banking capital. Government would also play a role in guaranteeing access of lower income groups to adequate health services both by incentives to encourage the expansion of philanthropic capital towards heealth services for the needy. During a transition phase, government voucher systems as well as state social services would have a role to play.

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Lessons from Switzerland

Historical Background:

Swiss social sickness insurance schemes are rooted in 19th century constitutional reforms. They were originally designed to guarantee access to care for lower income groups and industrial workers. More affluent groups growingly came to insure through subsidized sickness funds. This trend added to changes in the age pyramid and advances in medical technology, brought financial strains on an intricate multi-tiered system that until the mid 20th Century had functioned with clockwork efficiency. Cost-containment became a growing concern. This conducted to a new sickness insurance law (LAMal) in 1994. Sickness insurance was made compulsory. This enhanced the power of sickness fund cartels as well as the regulatory action of health care federal policy offices. Rationing processes have growingly been brought into the system affecting quality without influencing global costs. Arbitrary and in some cases unconstitutional strong-armed measures have also tended to enter the game.

Limits of Regulation

In 2002 federal government suspended the opening of private medical offices. This drastic measure that circumvents constitutional rights of doctors, stemmed from the assumption that costs are tied to the number of physicians. The Swiss Observatory of Healthcare demonstrated in 2007 that visits to doctors' offices were unrelated to GP density.

This ban grounds fully trained doctors in residency positions and disrupts training time lines for the younger physicians. Institutional contempt for doctors also sends a message that discourages students from going into medical careers. The “plethora” of physicians pummeled by regulators in 2002 has given way to a worrisome shortage that makes front-page news in 2007. This has also brought about a shift of primary care from generally cost-efficient doctor's offices to overloaded ambulatory services and emergency wards of costlier public hospitals. Here as in other experiments in government central planning scarcity inevitably comes to haunt the planners and the planned. Loss of quality and strife come next.

Switzerland shows no major differences with its neighbors with respect to number of acute hospital beds. It was second to Sweden in the ratio of nurses compared to hospital beds though the trend is changing: rationing nursing care is now part of the cost-containment picture in Swiss hospital and nursing home care[1]. The private hospital sector, open to citizens with supplementary insurance or to wealthy foreign patients, remains very active and offered 0.7 beds per 1000 population in 2000 (an increase of

17% from 1998). Between 1998 and 2000 the number of public hospital beds was hammered down by 6% through forced mergers of regional hospitals, closure of acute care units, centralizing of heavier technology and rationing of nursing care.

The downgrading of regional hospitals creates inequities in access to specialized care and to state of the art medical technology. Patients from small towns or from alpine valleys are often bounced from one local hospital to another before receiving appropriate care. Ambulances (and even helicopters) have come to replace elevators as a means of transfer from one specialty unit to another. Waiting lists in University hospitals have increased. High rates of critical incidents in larger hospitals, linked to medical errors, hospital infections and premature dismissals have been reported. Patients in the Geneva and Lausanne University Hospital Centers are particularly at risk with a rate of over 40% of complications according to a recently published *Comparis* study.

A constitutional initiative launched in 2004 proposed to replace the multiple insurer system by a single national insurance provider. It also proposed to peg insurance premiums to revenues. 72% of voters rejected the initiative in March 2007!
Another health care initiative designed to give insurers greater control over providers was again rejected in June 2008 by 69.5% of voters and all of the Cantons. Even in Switzerland, regulation has failed to live up to expectations. Cost containment measures have constricted hospital infrastructures and constrained medical activity with worrisome effects on quality and accessibility.

Dynamics of Reform

The conceptual flaw that makes present systems unsustainable in the long term lies in the fact that they cater simultaneously for risk and for probability. Actuarial assessment methodology is left out of the managing processes while the pay as you go system can not adapt to demographic pressures linked to changes in life expectancies that characterize human evolution. It is time separate risk

Medical saving accounts, risk related insurance, mutual help through voluntary pooling and reactivation of private charity and corporate philanthropy can indeed address sickness care far more efficiently and adequately than systems bthat rely exclusively on public financing and regulation. A truly free market enhances autonomy personal responsibility and innovation it also seeds out waste.

Health banking schemes basically designed for the covering of current and expected future health care expenses such as those of ageing, need to be completed by a strong private risk insurance sector with high deductibles that can parry unpredictable or catastrophic health accidents.

How can liberty oriented policy makers lead the move back to voluntary competition and free choice in health care? The famed Chilean reforms that sparked the global move towards the privatization of pensions show how capital might also be transferred to individual health care provision plans. Tax incentives either through tax credits or voucher systems can also seed-fund health banking accounts. Variants of this are presently being implemented in the US where recent additions to Medicare legislation allow citizens under certain conditions to claim tax sums from their individual retirement arrangements (IRA) in order to start Health Savings Accounts (HSAs). Singapore, implemented HSA's in 1984 in conjunction with social insurance for catastrophic illness. Singapore presently offers a successful example of cost effective and high tech quality care that has made it an attractive venue health tourism from other parts of Asia and Oceania.

A critical number of private hospitals is necessary for voluntary insurance to develop. In Switzerland for example, the strong private hospital sector (0.7 beds per 1000 population in 2000) is a powerful motor for voluntary private insurance products: it is open to citizens with supplementary insurance or to wealthy foreign patients, remains very active. The passage to a *monist" financing of hospitals (i.e. a wthdrawal of direct government subsidies to hospitals) is the object of ongoing discussions and debate in Switzerland today. The sustainability of the public hospital sector will probably depend on the introduction of public-private partnerships as is already the case in disciplines such as cardiology.

Financing of hospitals through their effective service charges rather than by subsidy stimulates accounting transparency and responsible management. Direct payment of health care providers by users who then claim reimbursements from insurance enhances cost-consciousness and competition. Co-payments and deductibles have the same effects.

III. Conclusion

Most industrialized nations are faced today with the need to reform health care systems that that cannot meet demographic and other challenges of the 21st century. The global move towards devolution of social security pensions to the market shows how present problems in health care can be solved. T
The first step to any lasting and successful reform is conceptual. In the case of health care what is required is a drastic segmentation of current models of financing in line with three fundamentally different objectives. a) The management of unpredictable health accidents through risk insurance and pooling b) the individual provision for predictable decline of health with age by developing appropriate health banking products c) the financing of care for the poor through government social services or by vouchers available to lower income groups and through the channeling of philanthropic capital towards health care. Increased competition by expansion of the private hospital sector and of private out-patient providers will enable prices in health

care to be checked by market mechanisms as they are in food or housing. Market friendly health care models will enable responsible policy makers to put an end to rationing spirals spawned by existing systems and will ultimately ensure that patients rich or poor receive the care that they need.

1 Schubert M. et al. Effects of Rationing in Nursing Care in Switzerland on Patients and Nurses' Outcomes: Basel Institute of Nursing Science, University of Basel 2004 (Unpublished report)

Research Director - Institut Constant de Rebecque
Contact: alphonse.crespo@ institutconstant.ch