The Decline of Social Insurance in Modern Healthcare

Lessons from Switzerland and beyond

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Abstract

Many envy Switzerland's pluralist healthcare insurance model. The subsidiary role set for the State together with a long Swiss tradition of political consensus fostered peaceful coexistence between subsidized social security and private market. 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 clamorous signal shows that the Swiss are ready for market reform of health insurance.

Most industrialized nations are faced today with the need to replace decaying coercive social security systems that were conceived in the 19th century and that cannot meet demographic and other challenges of the 21st century. The global move towards devolution of social security pensions to the market is now inspiring health policy makers. New models that combine high deductible risk insurance with health savings accounts are being implemented in countries as different as Singapore, the USA, South Africa and even China. 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 healthcare.

Transition costs of devolution of healthcare to the market can be minimized by policies aimed at rapid deregulation of insurance services and privatization of healthcare infrastructures. Fiscal incentives (tax credits, tax exemptions) can also facilitate the growth of health banking capital. Intimate knowledge of market dynamics together with an enlightened understanding of why and how liberty will ultimately improve healthcare services for all, is a prerequisite for a smooth implementation of such reforms. Free market think tanks have an important educational role to play in this respect. Governments who are wise enough to work with them will find contemporary solutions to the complex problem of funding modern healthcare.

Historical background

Swiss social sickness insurance funds rooted in 19th century constitutional reforms were originally designed for low income groups and industrial workers. Until the middle of the 20th Century the Swiss model functioned with clockwork efficiency ensuring both access and quality care to all. More affluent groups growingly came to insure through these subsidized funds. This trend, added to changes in the age pyramid and advances in medical technology, brought strains on an intricate multi-tiered system.

In the sixties the socialist party grew into one of the major contenders in the Swiss political arena and called for a collectivist approach to healthcare funding. Rising premiums of health insurance also became an ongoing political issue. This led to a sickness insurance law (LAMal) voted in 1994 that: a) introduced compulsory insurance b) extended regulatory powers of federal offices c) increased the weight of the insurance cartel in the parliamentary policy-making processes.

Some allowance was left for complementary private insurance and save for accident insurance, the pitfall of first dollar coverage was avoided. Although Switzerland is still rated among the top five healthcare systems by the European Health Consumer Index[1], the move from a truly pluralistic insurance model to a vulnerable more centrally planned system has affected costs and quality. It has also allowed counter-productive strong-armed measures to enter the game.

The Hazards of Regulation

In 2002 federal government arbitrarily suspended the opening of private medical offices. This drastic measure that circumvented constitutional rights of doctors, stemmed from the assumption that healthcare expenditures were tied to the number of practicing physicians. The Swiss Observatory of Healthcare demonstrated in 2007 that medical consultation was unrelated to GP density. This has not stopped the ban from continuing to this day.

The grounding of fully trained doctors in residency positions lastingly disrupts training flows for younger physicians. It also sends a message that discourages medical careers. The “plethora” of physicians pummeled by regulators in 2002 has given way to an alarming shortage that makes front-page news in 2007. Here as in other experiments in central planning, scarcity inevitably comes to haunt both the planners and the planned.

Rationing of practitioners has brought about a shift of primary care from generally cost-efficient doctor's offices to overloaded ambulatory services and emergency wards of public hospitals. Switzerland showed no major differences with its neighbours with respect to number of acute hospital beds. The number of public hospital beds has been mercilessly hammered down through forced mergers of regional hospitals, closure of acute care units,

[1] www.healthpowerhouse.com/media/RaportEHCI2006en.pdf

centralizing of heavier technology and rationing of nursing care. This has created inequities in access to specialized care and to state of the art medical technology. Waiting lists in University hospitals have increased. High rates of critical incidents in larger hospitals, linked to medical errors, hospital infections and premature dismissals are now being reported. Patients in the larger University Hospital Centres are particularly at risk with a rate of over 40% of complications judging by a recently published *Comparis* study.

In Switzerland as elsewhere Bismarckian social security has turned sour. Cost containment measures have constricted hospital infrastructures and constrained medical activity with worrisome effects on quality and accessibility. Regulatory sprees spawned by the 20th Century socialist solidarity dogmas have substantially moved healthcare away from the market. This logic however has run its time. A constitutional initiative launched in 2004 by trade unions and the socialist party called for another step towards socialization through implementation of a single national insurance provider. The initiative was rejected in March 2007 by 72% of voters. This has sent a clear signal to healthcare policy-makers and forecasts the comeback of friendlier approach to market in healthcare reform.

The private sector

A critical number of private hospitals is necessary for a local market of voluntary insurance to develop. Possibilities of access to off-shore treatment will offer marginal openings for private insurance in countries that lack private hospital alternatives and where state of the art care is constrained.

In Switzerland, the strong existing private hospital sector is a powerful motor for demand and offer of private insurance products and both sectors usually work together on promotional campaigns. The private hospital sector offered 0.7 beds per 1000 population in 2000 (an increase of 17% from 1998) and is constantly expanding. It now represents 20% of available hospitals beds in the country. The 1994 health laws fortunately allowed for supplementary private insurance. Over 30% of the Swiss opt for such schemes. In France and in the Netherlands the level of complementary coverage by voluntary health insurance is respectively estimated at 94% and 60%. Luxemburg (70%) and Ireland (45%) also boast high rates of voluntary private insurance coverage.[2]

High deductible risk insurance to parry unexpected catastrophic health accidents, coupled with individual health savings accounts for ordinary current and predictable healthcare expenses address sickness care far more efficiently and adequately than any system based on public funding and bureaucratic regulation. They show the way to the future.

[2] Euro Observer – Spring 2004 Vol 6, No1- European Observatory on Health Systems and Policies, WHO Regional Office for Europe, DK-2100 Copenhagen

Dynamics of change

How can liberty-oriented policy makers safely guide modern societies' move to private insurance, competition and free choice in healthcare? The famed Chilean reforms that sparked the global drive towards privatization of pension systems show how retirement plans can be successfully transferred to the private sector. This model can be extrapolated to healthcare provision. Tax credits or tax exemptions can seed-fund health banking accounts and stimulate private insurance. Variants of this are presently being implemented in the US where recent legislation now allows citizens to transfer sums from their Individual Retirement Arrangements (IRA) into Health Savings Accounts (HSAs) provided that they are coupled with high deductible health insurance plans. 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 healthcare financing through compulsory savings accounts have been carried out in China since 1994[3] : 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.

Conclusion

Marx and Bismarck are dead and buried. The ideological concepts that fathered our social security systems have become obsolete. The "winds of history" have turned for good: they now push healthcare towards the market. Free-market think tanks have an educational mission to accomplish: not only in supporting market reform in healthcare but also in clearing perceptions on what liberty can and will accomplish. This may help health policy makers open existing legal frameworks to new paradigms. In free societies however, individuals need not wait for legislation 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 helping the poor do the same. The must above all learn not to fear liberty.

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[3] Health Affairs, Vol V o l u m e 1 6 , N u m b e r 6
Http://www.content.healthaffairs.org/cgi/reprint/16/6/244.pdf