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**Towards More Choice
in Social Protection?
Individual Choice of Insurer
in Basic Mandatory Health
Insurance in Switzerland**

Francesca Colombo

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LABOUR MARKET AND SOCIAL POLICY - OCCASIONAL PAPERS N0.53

**TOWARDS MORE CHOICE IN SOCIAL PROTECTION?
INDIVIDUAL CHOICE OF INSURER IN BASIC MANDATORY HEALTH INSURANCE IN
SWITZERLAND**

Francesca Colombo

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EXECUTIVE SUMMARY

There is a considerable interest in some OECD countries in understanding how greater choice in health markets can be combined with the equity and efficiency goals of health systems.

This paper reviews the system of free choice of insurer in basic mandatory health insurance that was introduced in Switzerland with the 1994 Health Insurance Law (LAMal). The thrust of the reform was to increase solidarity in basic health insurance while enhancing choice among individuals and competition on quality-price ratios among insurers. The reform encompassed regulatory mechanisms to facilitate the switching mechanism and choice-led competition, such as measures to ensure cross-subsidisation across individuals of different risk and income, information disclosure requirements for insurers, and the mandatory participation to a risk equalisation mechanism for all insurers offering basic health insurance.

The analysis presented in this paper suggests that some features of the individual choice mechanism need to be reinforced to make it function better, and also suggest that the initial objectives of the choice system have not been fully attained yet. Conditions to facilitate liberty of choice of individuals are reviewed. However, the analysis also indicates that measures to improve the switching process should be accompanied by other interventions to foster competition on quality and efficiency rather than on risk selection. Promoting an increase in absolute rates of switching might otherwise come at a higher price than the benefits.

RESUMÉ

Certains pays de l'OCDE manifestent un très grand intérêt à comprendre comment un plus grand choix sur les marchés de la santé peut aller de pair avec des objectifs d'efficacité et d'efficience des systèmes de santé.

Ce rapport examine le système de libre choix du fournisseur de l'assurance-maladie de base obligatoire qui a été introduite en Suisse avec la loi sur l'assurance-maladie de 1994 (LAMal). Le but de la réforme était d'augmenter la solidarité de l'assurance-maladie de base tout en offrant un plus large choix à chaque individu ainsi qu'une concurrence au niveau qualité/prix parmi les assureurs. La réforme englobait des dispositifs réglementaires pour faciliter le mécanisme de changement ainsi que les mesures pour assurer un échange de subvention parmi les individus ayant des niveaux de risques et de revenus différents, des besoins en transparence d'informations pour les assureurs et la participation obligatoire dans un mécanisme d'égalité des risques pour tout assureur proposant une assurance-maladie de base.

L'analyse présentée dans ce rapport suggère un renforcement de certaines caractéristiques du dispositif de choix individuel pour que le système fonctionne mieux et suggère que les objectifs initiaux du système de choix ne sont pas encore totalement atteints. Les conditions pour faciliter la liberté de choix de chaque individu sont aussi examinées. Cependant, l'analyse indique également que des mesures pour améliorer la possibilité de changement devraient être accompagnées d'autres interventions pour encourager la concurrence en termes de qualité et d'efficacité plutôt que sur la seule sélection par rapport aux risques. Sinon, inciter une augmentation du taux de changement impliquerait que le prix soit plus élevé que les bénéfices.

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1. INTRODUCTION

1. Many OECD countries have looked for ways to combine solidarity with competition and choice¹. Greater choice may allow individuals to satisfy more accurately their preferences and enhance health systems responsiveness. Moreover it may create competitive pressures on providers and third party payers to improve efficiency and quality². However, trade-offs between individual liberty and social goals of equity might exist. Private initiatives in the health care market may fail to deliver social goals because of endemic market imperfections, such as informational asymmetries, externalities and the presence of public goods³. There is hence an interest in understanding under what conditions greater choice in health markets is beneficial, through which mechanisms individual choice can be expressed more effectively, and who benefits (or conversely loses) from greater choice.

2. This paper investigates individual choice of insurer in the Swiss basic health insurance system and offers preliminary indications of the effectiveness of the choice mechanism. Switzerland constitutes a perfect ground for studying individual choice in health, because consumer sovereignty is regarded as a pillar of the health care system. Moreover the Swiss case is unique across OECD countries for the mechanism of regulated competition through which it promotes freedom of choice, solidarity, and cost containment in mandatory private health insurance. The study sheds some light on the 1994 Health Insurance reform that adopted the tool of individual choice in order to encourage insurers' competition on quality-price ratios. The intent of the reform was to combine the efficiency and quality gains of a contestable market for health insurance with fairness in the distribution of the burden of payment for insurance cover and mandated health insurance coverage for all. While the 1994 Health Insurance reform introduced important regulatory mechanisms to tackle the risks of adverse selection⁴ and risk selection⁵, it is debatable whether some of the initial goals of the reform have been fully attained. Nonetheless, the review of the Swiss health insurance reform might offer insights to policy makers intending to adopt similar tools in other OECD countries.

3. This paper is structured as follows. The next section describes the 1994 Health Insurance Law (LAMal⁶) that introduced the principle of freedom of choice of insurer. Section 3 focuses on the choice mechanism. It reviews its legal and institutional framework, the goals behind it, and the factors that may affect individual choice of insurer. It then reviews the structure of the health insurance market. Section 4 assesses existing evidence on the effectiveness of the choice of insurer mechanism. It looks at individuals' behaviours; the effectiveness of mechanisms supporting the individual choice process; and preliminary evidence on the fulfilment of initial goals of the choice mechanism. Section 5 discusses the major findings of the study and reaches conclusions.

1. OECD (1994). See Annex 1 for a categorisation of cases of choice in health systems.

2. Saltman, R.B. and Von Otter, C. (1989).

3. Arrow (1963).

4. Adverse selection, a demand-side phenomenon, occurs when insurance premiums are community-rated or imperfectly risk-adjusted. Individuals whose premiums are overrated for their true risk tend to exit insurance, thus increasing the costs of coverage for insurees remaining in the pool. Adverse selection can be reduced by improving risk adjusting, compelling or encouraging individuals to participate in the pool.

5. Risk selection, a supply-side phenomenon, occurs when insurers discourage participation of bad risks (cream skim) in order to reduce payments for claims. Insurers face strong incentives to select risks when they cannot adjust premiums to risk, which can be offset through an effective risk equalisation mechanism.

6. Loi fédérale sur l'assurance-maladie, LAMal.

2. THE SWISS HEALTH INSURANCE SYSTEM AND THE NEW HEALTH INSURANCE LAW (LAMAL)

4. The Swiss health sector is financed mainly by private health insurance purchased by individuals (table 1). The taking out of policies for basic health insurance is mandatory.⁷ Besides mandatory basic health insurance, currently provided only by not-for-profit sickness funds⁸, individuals can take up voluntary cover, provided both by sickness funds and private for-profit insurers. Only about a fifth of the population is covered by complementary voluntary insurance, representing about 15% of overall health financing in 1998⁹. Individuals pay providers fee-for-service and subsequently insurers reimburse patients for their medical bills. In case of hospitalisation, insurers can either pay hospitals directly ('système du tiers payant') or reimburse individuals ('système du tiers garant'). The payment method varies depending on the Canton and sometimes the hospital. Hospitals are predominantly reimbursed as a lump sum ('forfait obligatoire'), but can also be paid through per-day payments. Professionals are independent and paid fee-for-services. Overall health care expenditures have grown rapidly for the past decades (Table 2), reaching 10.4% of GDP in 1998. A slow down in expenditure growth seems to have occurred since the beginning of the 1990s¹⁰ (figure 2). Switzerland spends more on health care than most other OECD countries, ranking third after the USA and Germany for expenditures as share of GDP and ranking second after the USA in per capita terms (Table 3). Wide variations exist across Cantons, with French speaking Cantons showing higher consumption levels than German or Italian speaking Cantons.

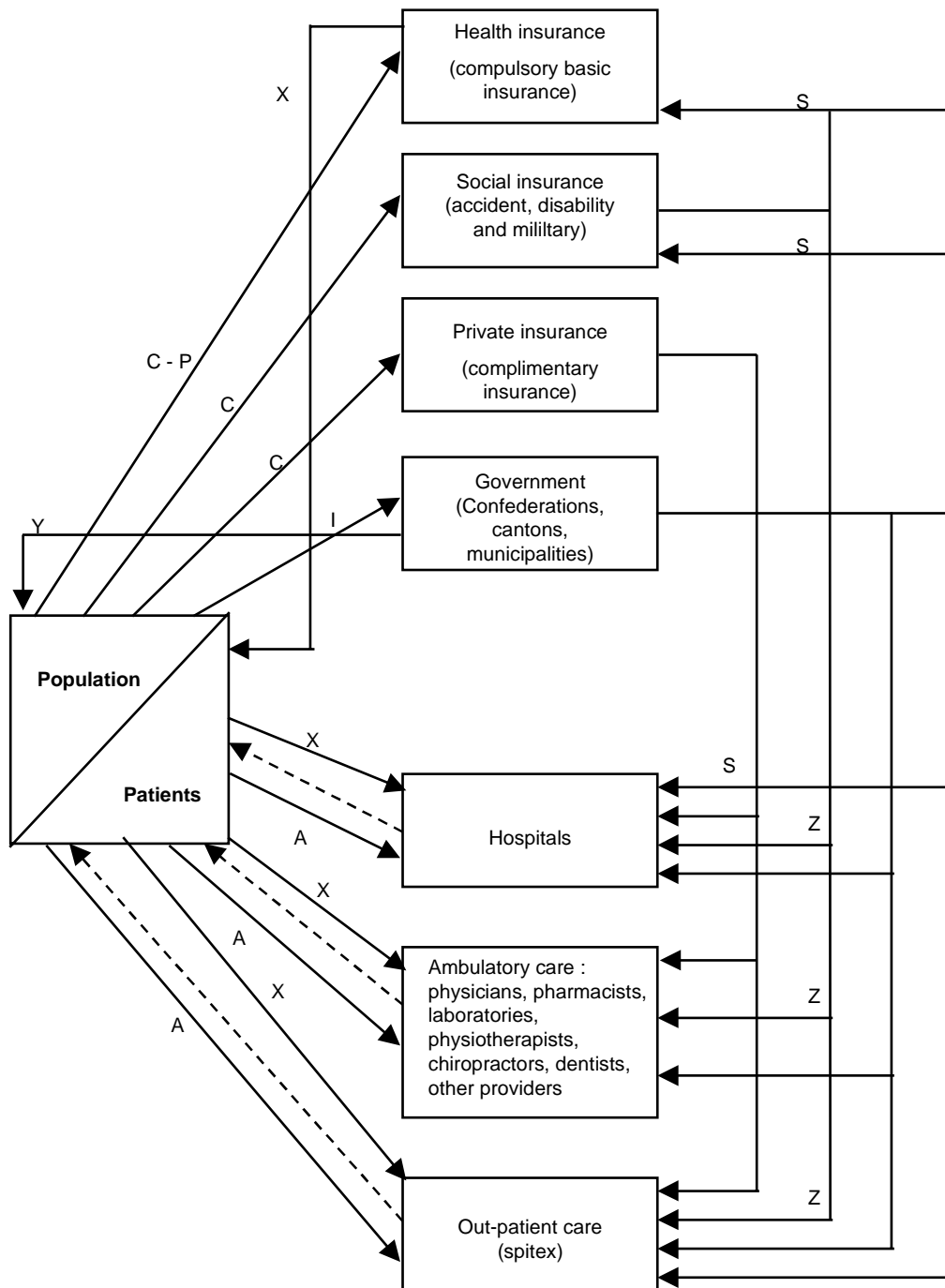
7. For a description of the Swiss health system see the following: European Observatory (2000); OECD (2000); OFAS (1998e); Lehmann et al. (1989); Hoffmeyer, U. & Whitaker, D. (1994); Frei & Hill (1990).

8. According to the LAMal, also private insurers could obtain authorisation to provide basic health insurance cover.

9. Calculated from data of OFAS (Office Fédéral des Assurances Sociales) and OFAP (Office Fédéral des Assurance Privées). The figure includes voluntary health insurance provided by sickness funds and private insurers.

10. Two Emergency Federal decrees were adopted at the beginning of the 1990s, moreover the LAMal entered in force in January 1996. While this paper does not analyse the determinants of the slowing in expenditure growth, the introduction of the two decrees might offer an explanation.

Figure 1. The Swiss Health Care system



- | | | | |
|----------------------|-----------------|-----------------------|--------------------------------------------------------------------------|
| A: Self-pay patients | I: Taxes | S: Subsidies | X: Reimbursements of third parties guaranteed in the sickness insurance. |
| C: Contributions | P: Cost-sharing | Z: Third-party payers | Y: Primary reduction for the low income insurees |

Source: Office fédéral de la statistique, Bern.
 Copyright: OECD Health data, 2000.

Table 1. Health expenditures in Switzerland by source of funds

	1985	1990	1994	1995	1996	1997	1998
General Government (1)	17.80%	18.84%	16.51%	15.81%	15.84%	15.35%	14.75%
Private social health insurance and private voluntary health insurance:							
- Sickness funds (2)	37.01%	37.79%	41.41%	42.29%	43.59%	42.44%	42.64%
- Private insurers (3)	0.00%	0.00%	1.30%	1.00%	1.17%	1.19%	1.16%
Other social insurance schemes (4)	8.50%	8.61%	10.14%	10.18%	10.24%	10.43%	10.58%
Out-of-pocket (5)	33.59%	32.41%	28.83%	28.85%	27.44%	28.44%	28.75%
Other payments (6)	3.10%	2.35%	1.81%	1.88%	1.72%	2.15%	2.13%
TOTAL	100%	100%	100%	100%	100%	100%	100%
TOTAL (Million CHF)	18,384	26,279	33,817	35,050	36,960	38,044	39,527

Source: Compiled from data from the Office Fédéral de la Statistique (1999).

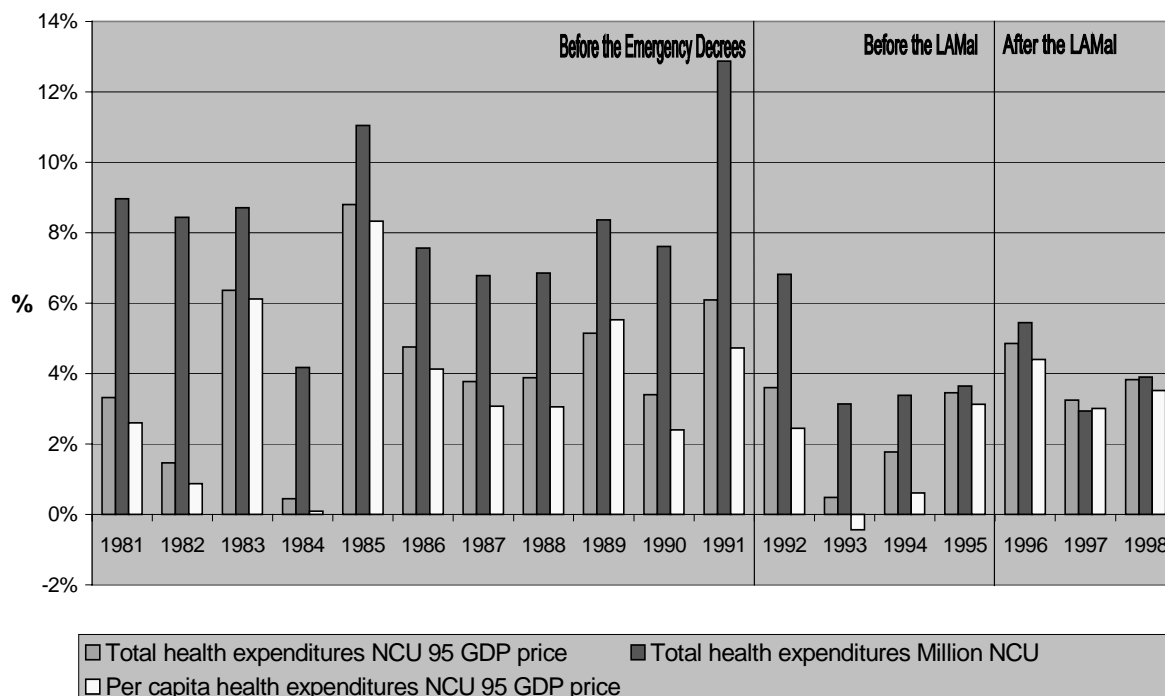
- (1) Federal Government, Cantons and municipalities
(2) Basic mandatory and complementary voluntary health insurance at sickness funds, including gross premiums, government subventions, capital and extraordinary revenues.
(3) Complementary voluntary health insurance at private insurers
(4) Other health expenditures under social insurance schemes: occupational and non-occupational accident insurance, military insurance and disability insurance.
(5) Direct payments from households and cost sharing in health insurance schemes
(6) Payments for services provided to individuals who reside abroad

Table 2. Evolution of health care expenditures in Switzerland

	1970	1975	1980	1985	1990	1995	1996	1997	1998
Total expendit. on health - Million NCU	4,697	9,810	12,373	18,383	26,308	35,050	36,960	38,044	39,527
Total expendit. On health - /capita, NCU 95 GDP price	1,981	2,763	3,157	3,759	4,492	4,978	5,197	5,353	5,541
Total expendit. On health - % gross domestic product	4.9	6.6	6.9	7.7	8.3	9.6	10.1	10.3	10.4

Source: OECD HEALTH DATA 2000

Figure 2. Evolution of health expenditures in Switzerland (year-to-year percentage changes) before and after relevant legislative measures¹¹



Source: OECD HEALTH DATA 2000

5. The new Health Insurance Law (LAMal) was ratified in a popular referendum in 1994, under growing cost containment and solidarity concerns resulting from the 1911 Federal Law on Sickness and Accident Insurance (LAMA). The LAMA, a Federal Law inspired by a Bismarkian model of social insurance, established a basic benefit package, nonetheless affiliation remained predominantly voluntary and insurance conditions varied greatly across sickness funds. Individual premiums were calculated on the basis of the age of entry in the fund and the sex of the person insured. Premiums for women could be as much as 10% higher than those for men, while age of entry in the fund determined large premium variations¹². Nominal premiums were unrelated to earnings. Bad risks could not move freely across insurers because sickness funds could cream skim and charge premiums irrespective of previous sickness funds affiliation. Solidarity was difficult to achieve under such conditions. Competition across sickness funds was not fair either. While sickness funds received financial subsidies from the government, these did not account well for differences in risk structures across insurers. Funds with a higher percentage of bad risks were forced to charge higher average premiums, which created an adverse selection incentive for younger and healthier cases to leave the fund. Some sickness funds disappeared from the market or had to merge with others to avoid bankruptcy. Although the need to revise and modernise the LAMA emerged since the 1960s, the voters rejected all attempts to correct its weaknesses until finally the new Health Insurance Law was adopted.

11. These refer to: A) Two emergency decrees: 1) Temporary measures to reinforce equity in health insurance (in force since December 1991); 2) Measures aiming at curbing rising costs (in force since October 1992); B) the new Health Insurance Law (LAMal, in force since January 1996).

12. Bonoli (1997).

Table 3. Total expenditures on health in OECD countries

	As % of GDP		Per capita US\$ PPP		
	1990	1998	1990	1998	Rank
USA	12.4	13.6	2,755	4,178	1
Germany	8.7	10.6	1,602	2,424	3
Switzerland	8.3	10.4	1,782	2,794	2
France	8.8	9.6	1,545	2,077	9
Canada	9.2	9.5	1,702	2,312	5
Norway	7.8	8.9	1,365	2,425	4
Belgium	7.4	8.8	1,246	2,081	10
Netherlands	8.8	8.6	1,403	2,070	11
Australia	7.9	8.5	1,318	2,043	12
Italy	8.1	8.4	1,321	1,783	15
Sweden	8.8	8.4	1,548	1,746	16
Denmark	8.4	8.3	1,442	2,133	7
Greece	7.6	8.3	706	1,167	23
Iceland	8	8.3	1,377	2,103	8
Austria	7.2	8.2	1,209	1,968	13
New Zealand	7	8.1	937	1,424	20
Portugal	6.4	7.8	614	1,237	21
Japan	6.1	7.6	1,083	1,822	14
Czech Rep.	5	7.2	575	930	24
Spain	6.9	7.1	811	1,218	22
Finland	7.9	6.9	1,292	1,502	17
Hungary	...	6.8	...	705	26
U.K.	6	6.7	964	1,461	18
Ireland	7	6.4	796	1,436	19
Poland	5.3	6.4	258	496	27
Luxembourg	6.6	5.9	1,485	2,215	6
Korea	4.8	5	370	730	25
Mexico	3.6	...	213	...	
Turkey	3.6	...	171	...	
OECD average – unweighted	7.6	8.3		1,891	

Source: OECD HEALTH DATA 2000.

6. The new Health Insurance Law (LAMal) was approved by Parliament and subsequently ratified by a popular referendum in 1994. It came into effect on 1 January 1996. The LAMal refers only to basic health insurance and targets explicitly the shortcomings of the LAMA system. Its main legal provisions, which are summarised in Table 4, can be directly related to the three main objectives pursued by the law¹³:

- Strengthening solidarity within basic health insurance by ensuring equality of individuals with different income and health risk.
- Containing health expenditures through a mix of demand and supply-side measures.
- Guaranteeing high quality and adequate basic health services.

13. These objectives were contained in the Message concerning the revision of the Health Insurance Law, 6 November 1991, pp. 3-5. See also OFAS (1998c), p. 2.

Table 4. Main provisions of the LAMal by objective

OBJECTIVES OF THE LAMal			
Solidarity	Cost containment		Quality of health care services
	Demand side measures	Supply side measures	
<ul style="list-style-type: none"> • Universality and access: - Art. 3. All residents in Switzerland are compelled to take up basic health insurance. - Art 106. Subsidies are means-tested and paid by Cantons directly to low-income individuals. The cost of such subsidies is shared between the Confederation and the Cantons. • Elimination of cream skimming incentives. - Art 4. LAMal- Insurers are compelled to accept all individuals without making reservations. - Art 61. Insurers cannot risk adjust premiums for basic health insurance. Insurers can only apply three premium echelons per Canton reflecting variations in health cost. 3. Non-profit requirement . - Art 13. Insurers offering basic health insurance cannot pursue or realise profits in this branch of operations. 	<ul style="list-style-type: none"> • Adequacy of benefits: - Art 32. The adequacy and cost-effectiveness of medical benefits must be demonstrated according to scientific criteria - Art 56. Insurers can refuse to pay benefits provided beyond need. • Competition on the financing side: - Art 4. Individuals are free to choose insurer and to move across insurers. - Art 105. A risk equalisation system was set up to compensate insurers for differences in cost arising from differences in risk structures linked to the age and sex structure of insurees. • Cost sharing: - Art 64. All individuals share in the cost of health services. - Art 62. Individuals can choose special forms of basic health insurance: a)“Assurance à option”: higher deductibles coupled with lower premiums. b) “Assurance avec bonus”: annual premium reductions if no claims are made during the period. 4. Other - Art 22 and Art 61. The Swiss Federal authorities exercise a control over insurers’ administrative costs and approve premium levels. 	<ul style="list-style-type: none"> • Hospital planning and global budgets. - Art 39. Introduction of hospital planning. Cantons and Sickness funds share the costs of hospital services. - Art. 51. Cantons can allocate resources to hospitals through global budgets. • Tariff conventions - Art 46. Tariffs conventions negotiated between insurers and providers associations are subject to approval on the basis of economy and equity criteria. • Managed care - Art. 41 and Art. 62. Insurees may limit their choice of providers and thus obtain reductions in premiums (HMO and IPA options¹⁴). Managed care is meant to contain costs by shifting the risks of medical expenditures from insurers to providers. 	<ul style="list-style-type: none"> • Basic package of services - Art 25-32. The Law specifies the services included in the basic compulsory health insurance package. Services must be adequate and cost-effective. • Quality monitoring - Art 58. The Federal Council can carry out scientific and systematic controls to ascertain the quality and adequacy of health care services provided under the LAMal.

14. Health Maintenance Organisations and Individual Practice Associations.

7. While maintaining the principle of participation on an individual basis, the LAMal mandated a minimum basic level of protection for all, leaving however individuals free to express their preferences over insurers and providers. The Law introduced six key changes to the LAMA health insurance system:

- Mandatory affiliations. All residents are compelled to purchase basic health insurance coverage at one of the LAMal-insurers, i.e. insurers who obtained federal authorisation to offer basic health insurance.
- Standardised benefits. Basic health insurance covers in-kind medical benefits and pharmaceuticals¹⁵. The Law establishes all medical benefits included in the basic health insurance cover.
- Uniform premiums. LAMal insurers establish their own premiums competitively but have to charge uniform premiums to all their insurees, irrespective of individual risk. Reduced premiums apply to children and young people.
- Cream skimming not allowed. LAMal-insurers cannot discriminate between individuals on the basis of their risk status: they cannot adjust premiums to risk, refuse any individual or make reservations.
- Means-tested subsidies. Federal and Cantonal subsidies, previously allocated to sickness funds, are now targeted to low-income individuals.
- Risk compensation. A risk equalisation mechanism is established to eliminate incentives for insurers to cream skim and to ensure solidarity across insurers with different risk structures.

8. Three major outcomes of the reform are relevant for this study. First, the LAMal established a mechanism of free choice and free switch across insurers, which is applicable to basic health insurance only. The goals and effects of 'freedom of choice' will be analysed in greater detail in sections 3.2 and 4.3. Second, the LAMal placed great importance on establishing mechanisms to ensure that choice of insurer takes place on an equal basis for all individuals, and that insurers' competition, stimulated by choice, occurs fairly across insurers. These mechanisms will also be reviewed because they have a direct effect on individuals' choice of insurer (sections 3.3 and 4.2). Third, the new health insurance reform introduced a clear-cut regulatory separation between basic compulsory health insurance, regulated by the LAMal, and complementary voluntary health insurance, regulated by the Insurance Contract Law (LCA¹⁶).

9. Basic health insurance can only be practised separately from other insurance contracts, and without pursuing a profit motive. Insurers willing to offer basic health insurance need to seek authorisation from the Federal Department for Home Affairs. Certain requirements pertaining to the adequacy of the financial and organisational structure need to be met to obtain authorisation. While both private health insurers and sickness funds can become LAMal-insurers, so far only sickness funds have been active in the basic health insurance market¹⁷. Conversely, both sickness funds and private insurers practice complementary health insurance. Responsibility for the supervision of players is shared among the Federal Social Insurance Office (OFAS), the Federal Private Insurance Office (OFAP) and the Cantons (table 5). The Federal Social Insurance Office is responsible for the institutional surveillance of sickness funds and the supervision of basic health insurance activities¹⁸. The Federal Private Insurance Office is responsible for the institutional surveillance of private insurers and the supervision of voluntary health insurance

15. These encompass all services received by a doctor, medical treatment in general hospital wards, and prescribed generic pharmaceuticals from a drug speciality list.

16. Loi fédérale sur le Contrat d'Assurance.

17. So far there have been no cases of private health insurers asking for authorisation to provide basic cover. For this reason, this paper uses the terms LAMal-insurers and sickness funds interchangeably. Obviously, private health insurers wishing to offer basic mandatory health insurance will have to separate this practice, a non-profit activity, from other activities where the insurer can pursue a profit.

18. Insurers practising the LAMal have to submit to OFAS annual reports, including their budgets and financial reports, and communicate the list of premiums charged for the following year. OFAS is also responsible for monitoring the financial sustainability of sickness funds.

activities that are subject to the regulation of the Insurance Contract Law, even when these are provided by sickness funds. Cantons are responsible for checking individual's affiliation to basic health insurance and can insure automatically all individuals who have not done so by themselves¹⁹. They are also responsible for the organisation of the subsidy system for low-income persons.

Table 5. Supervision of players in the health insurance market and supervision of health insurance practices.

Supervision Method Activity	<i>Surveillance of insurance practices</i>				<i>Surveillance of players</i>	
	<i>OFAS</i> ¹	<i>OFAP</i> ²	<i>Canton</i>	<i>Federal Council</i>	<i>OFAS</i>	<i>OFAP</i>
Mandatory basic health insurance	✓		Controls individual Affiliation	Provides authorisation of providers	Sickness funds	-
Daily Cash-benefit insurance	✓ (under LAMal ³)	✓ (under LCA ³)			Sickness funds	Private insurers
Voluntary complementary insurance		✓		Provides authorisation of providers	Sickness funds	Private insurers

¹ *Office Fédéral des Assurances Sociales*

² *Office Fédéral des Assurances Privées*

³ *Daily Cash-benefit insurance is taken up voluntarily and can be provided under the legislative framework of both the Health Insurance Law (LAMal) and the Insurance Contract Law (LCA).*

19. Automatic enrolment is carried out by a Canton Authority. While the insuree will not have choice over the insurer, she will still be liable for paying the basic health insurance premiums.

3. INDIVIDUAL CHOICE OF INSURER IN BASIC MANDATORY HEALTH INSURANCE

10. This section looks in detail at the choice mechanism. It analyses the legal and institutional framework underpinning individual choice, the goals the Swiss legislator intended to pursue when introducing the principle of freedom to choose and switch, the elements that can affect individual's choice, and the structure of the Swiss health insurance market.

3.1 Institutional and legal framework of the choice mechanism

11. The LAMal allows individuals to move basic health insurance cover freely across LAMal-insurers, but only within the Canton where they reside or work²⁰. Cantons can hence be considered mutually exclusive markets: people are not allowed to shop for basic health insurance products across Cantons' boundaries, although most sickness funds operate in more than one Canton.

12. Supposedly, all individuals can choose their LAMal-insurer freely due to three conditions:

- LAMal-insurers have to accept all persons within their territory of operation, regardless of individual risk.
- LAMal-insurers cannot make reservations on taking out of basic insurance cover. Conditions apply equally to all individuals at any given fund.
- Each LAMal-insurer applies risk-invariant premiums to all individuals insured by the fund, irrespective of age of entry. Premiums are community-rated at fund level but can vary across insurers.

13. The principle of 'free choice of insurer' constitutes a departure from both the previous Sickness and Accident Insurance Law (LAMA) and the Insurance Contract Law (LCA). This principle does not apply to complementary health insurance, where insurers can adjust premiums to risk, refuse bad risks, and terminate the insurance contract should the individual fail to disclose all health and medical conditions affecting his/her risk status. The LCA applies to insurance cover for all medical benefits not included in the LAMal. It also applies to hospitalisation in semi-private and private accommodation.

14. Individuals can switch LAMal-insurer at the end of June and December in any given year. However switches occur predominately at the end of the year, when sickness funds communicate their new premiums for the year to come²¹. Individuals have to communicate their decision to change sickness fund within 30 days of receiving the notice. The fund can oppose an individual's switching decision only if

20. However, existing statistics suggest that some people might have taken insurance cover in a different Canton from the one of residence. This could be for example the case of students moving to school in a different Canton.

21. Sickness funds have to give written communication to all people insured of the premium levels they apply for the following year at least two months in advance of the changes (i.e., on 31 October for changes taking place on the 1st of January). The written notice will also remind the individuals of their right to switch insurer.

premiums have not been paid in their entirety. In compliance with the mandatory nature of basic health insurance, individuals are also bound to send to the old insurer an attestation certifying that cover has been taken with a different fund. People holding a special basic insurance contract²² can only decide to switch insurer on 31 December, subject to a three months' notice.

3.2 Goals of individual choice of insurer

15. Although it is difficult to distinguish the goals of "free choice of insurer" from the general objectives of the LAMal, three specific goals seem to be central:

- Intensifying insurers' competition in the basic mandatory health insurance market.
- Creating cost containment incentives for LAMal-insurers.
- Strengthening individual liberty to choose insurer.

16. The first goal is based on the assumption that the free choice of insurer mechanism will transmit market signals and thus strengthen competition among sickness funds, as individuals move to seek the most convenient option. Effective competition in the basic Swiss health insurance market requires two conditions. First, people insured should be sensitive to the comparative performance²³ of insurers. If people do not switch or do not choose better performing insurers, the free choice of insurer mechanism will not transmit market signals to insurers and competitive pressures will not intensify. Second, insurers should engage in a 'healthy competition' on quality-price ratios rather than competing indirectly²⁴ on selecting good risk. If insurers compete on risk selection, sickness funds with worse-than-average risk structure could be condemned to exit the market regardless of their efficiency level. Whether both conditions are currently met will be analysed later in the paper (section 4.1 and 4.3).

17. The second goal is based on the assumption that the system of free choice of insurer will generate cost-containment pressures on insurers and that these will act accordingly. If insurers compete to attract individuals, they face incentives to improve their benefit-cost ratios. Since the law fixes all medical benefits included in the basic cover and prevents LAMal insurers from obtaining any profit on basic health insurance, sickness funds will have to compete on efficiency gains. Under competitive pressures, insurers are supposed to implement cost reducing strategies, seeking to compress either administrative costs or medical costs. Whether insurers have currently the incentives to implement such strategies will be discussed in section 4.3.

18. The third goal of the individual choice of insurer system is to enhance individual freedom. The existence of choice mechanisms well reflects the importance attributed in the Swiss Federation to liberty values²⁵. Consumer choice is considered an optimal way for tailoring people's needs. Systems can be made accountable to consumers by allowing greater consumer sovereignty because demand signals create pressures for system responsiveness. Obviously, the effectiveness of the choice mechanism in enhancing

22. These include insurance with higher deductibles, bonus insurance and insurance with limited choice of provider (see section 3.4). For insurance with higher deductibles and bonus insurance, individuals cannot exercise their right to switch respectively in the first year and the first five years since taking up insurance cover.

23. Performance include price and quality factors that differentiate the offer of one sickness funds from other funds.

24. Insurers are not directly allowed to select risks. However, they could risk select indirectly (see section 4.2).

25. European Observatory of Health Care Systems (2000); Lehmann P., Gutzwiller, F. and Martin, J.F. (1989).

individual liberty is based on the assumption that consumers are well informed and that all can switch on an equal basis across sickness funds. These conditions will be reviewed in section 4.2 and 4.3.

3.3 Mechanisms to support free choice of insurer

19. The legislator has placed emphasis on provisions that should guarantee the smooth functioning of the choice mechanism and facilitate the achievement of its goals. Three of them are especially relevant:

- Provisions to ensure that all insurees can choose on an equal basis regardless of risk and income.
- The risk compensation mechanism, that was established to promote solidarity across insurers with different risk structures.
- Requirements for information disclosure towards individuals insured.

20. Choice of insurer can take place on an equal basis if there is no discrimination between individuals of different income, age and health status. This requires cross-subsidisation from low-risk to high-risk individuals and from high-income to low-income individuals. Theoretically, equity would be guaranteed in a competitive health insurance market with risk-adjusted premiums if subsidies to low-income and high-risk individuals were perfectly targeted. In practice, other arrangements are necessary because targeting is subject to frequent errors²⁶. Cross-subsidisation from low-risk to high-risk individuals is promoted in Switzerland through risk pooling: premiums are community-rated within each sickness fund and risk selection is prohibited. As to differences in income, individual premiums are not income-adjusted but the LAMal introduced means-tested subsidies to eligible low-income individuals²⁷. The Swiss Federal Council fixes both the subsidies allocated from the Federation, calculated on the basis of the resident population and the economic capacity of the Canton, and the minimum contribution to be paid by the Cantons, at least equal to half the federal subsidy. Each Canton establishes eligibility criteria for individuals.

21. A risk compensation mechanism was established in 1992 in order to compensate sickness funds for the differences in costs that originate from differences in risk structures across funds, but not from differences in efficiency²⁸. Insurers with an age and gender structure more favourable than the Swiss average must pay money to a common pool (“institution commune”) to compensate sickness funds with a less favourable risk structure²⁹. The risk compensation provides for transfers across insurers on a Canton by Canton basis. The contribution is intended to stimulate solidarity for individuals by reducing incentives for insurers to cream-skim, and to promote solidarity among sickness funds by spreading risk across insurers. According to the LAMal, the mechanism will be maintained only for 10 years after which the risk structure is supposed to equalise across sickness funds and the compensation system become superfluous. The continuation of the risk compensation mechanisms beyond 2006 is currently the object of debate.

22. A key element for the smooth functioning of health care markets is that all consumers have access to the same information as do providers and purchasers of health services, and understand it. If this condition is satisfied, individuals will be able to judge for themselves the value of the products offered on the health market, for example a health insurance package, its price, its quality and related customer

26. Two common types of targeting mistakes include: a) subsidies reaching individuals outside of the target group; b) subsidies not reaching targeted individuals. Steward & Cornia (1995).

27. Under the previous legal regime (LAMA) sickness funds with a worse-than-average risk structure received public subsidies in order to preserve their financial viability.

28. OFAS (2000b).

29. 30 risk groups were established: 15 age groups, each divided into 2 gender groups.

service³⁰. The existence of information failures within health markets requires governments in some circumstances to replace private markets. The Swiss regulator imposed information disclosure requirements to help individuals make more informed decisions. This regards mandatory information requisites for LAMal-insurers, concerning their activity, financial reports, and premium charged. It also includes the opportunity for individuals to request additional information and oppose insurers in case of disagreement with their decisions. Finally, individuals can seek advice from patients and consumers organisations that provide counsel and assistance³¹.

23. The effectiveness of these mechanisms will be reviewed in section 4.2.

3.4 Elements that can affect choice of insurer

24. Three main groups of factors can affect choice of insurer in basic health insurance:

- Non performance-related variables such as habit, tradition and family history.
- Performance-related variables such as price (premiums) and quality (service quality and availability of various insurance products).
- Variables related to the market structure of each Canton, such as the number and size of sickness funds.

Performance-related variables

Price variables

25. Price variables refer to the out-of-pocket price of insurance cover (premiums and cost sharing).

- *Premiums.* Premiums vary across insurers and, for each insurer, across the Cantons where it operates. The law allows also additional premium differentiation. First, individuals who already benefit from compulsory accident insurance can ask for a reduction in the basic insurance premium, which include cover for accidents. Second, each insurer is allowed to set three levels of premium for three different regions in each Canton, which should reflect differences in the cost of providing health services. Third, the insurer can charge three age-related categories of premiums: children (0-18 years), young people in training (19-25) and adults. Fourth, individuals choosing special categories of basic health insurance³² can obtain premium reduction. As a result, premiums for basic health insurance can vary substantially both within and across Cantons. The average premium³³ in the Geneva Canton was two and half times as much that of the AI Canton during 2000. Large variations also exist between the minimum and the maximum premium charged in any Canton.
- *Cost sharing.* The level of cost sharing does not affect the choice of insurer because cost sharing is invariant across insurers. The law fixes the degree of cost sharing in an annual deductible of 230 CHF on basic health insurance cover. A coinsurance of 10% applies to all health costs in excess of the

30. Ovretveit, J. (1996). Le Grand, J. (1991).

31. For example: the Swiss Organisation of Patients (Zurich-based), the Romand Federation of Consumers (Lausanne-based), and the Swiss Association for the defence of Social Insurance Users (Carouge-based); Pro mente sana, etc.

32. Insurance with higher deductibles, insurance with limited choice of providers and bonus insurance.

33. Weighted average of the premiums paid by people insured at the largest 28 sickness funds in Switzerland (ordinary level of deductibles, adults).

deductible, up to an annual ceiling of 600 CHF (CHF 300 for children). A daily co-payment of 10 CHF applies in case of hospitalisation.

Quality variables

26. Three main quality variables could affect choice of insurer: the composition of medical benefits, the type of insurance products available from an insurer, and other difficult to measure variables such as insurer's reputation and service quality.

- *Medical benefits.* Basic health insurance benefits are standardised across insurers hence they do not constitute an element of choice.
- *Insurance products.* Sickness funds can offer 4 types of basic health insurance (ordinary health insurance, insurance with higher deductibles, insurance with limited choice of providers, bonus insurance) and 2 types of voluntary health insurance (daily cash insurance and complementary health insurance). While all LAMal-insurers provide ordinary insurance, insurance with choice of deductible and daily cash-benefits insurance, only about one in four provides HMO insurance³⁴, and one in seven provides bonus insurance in any canton. Half of the LAMal-insurers offers complementary insurance cover. The availability of complementary benefits would be relevant to the choice of a sickness fund should individuals find it difficult to keep basic and complementary insurance cover in different funds, a condition that will be analysed later in the report.
- ✓ Ordinary basic health insurance allows individuals free choice of doctor and requires them to pay ordinary premiums and an annual deductible of CHF 230 per year ('franchise legale').
- ✓ Insurance with choice of deductible ('franchise à option') requires individuals to pay a higher level of co-payments, in exchange for a reduction on ordinary premiums. Insurance with choice of deductible is supposed to encourage cost containment by increasing cost sharing.
- ✓ Bonus insurance ('assurance avec bonus') requires individuals not to make any reimbursement claim during a year in order to obtain a premium reduction from one year to the next. Individuals have to commit for a minimum of 5 years. Bonus insurance is supposed to allow for cost containment by increasing cost sharing.
- ✓ Insurance with limited choice of providers (HMO) allows individuals to obtain premium reductions on their basic health insurance policy if they agree to use only certain designated providers from a Health Maintenance Organisation (HMO) or an Individual Practice Associations (IPAs)³⁵. Managed care doctors act as gatekeeper of the patient's health. Managed care is intended to allow for cost containment in two ways. First, by involving individuals in a tighter relationship with primary care providers, it is meant to facilitate a more responsible use of health care services and the referral system. Second, it induces providers to limit unnecessary health interventions because providers are mainly not paid on a fee-for-service basis but capitation, a fixed per capita amount that is meant to cover both medical and administrative costs³⁶.
- ✓ Voluntary daily cash-benefit insurance provides a daily allowance covering loss of income due to illness. This insurance cover can be offered under the regime of the LAMal but the insurers can choose to offer daily cash-benefit insurance under the more flexible arrangements of the Insurance Contract

34. This also includes IPA practices.

35. In the first case, HMOs consist of a single group-based medical practice employing a general practitioner (GP), few specialists and other health care professionals. In the second case, several medical practices operate from individual premises but they are linked in a network.

36. Payment mechanisms based on fee-for-service create incentives for providers to boost service delivery, while capitation is more effective in containing costs because it transfers part of the risk of insurers onto providers. WHO (2000), p. 106.

Law. Often this type of insurance is taken up as group insurance by employers for their employees and covers the obligations they have to continue paying wages in the event of illness or injury.

- ✓ Voluntary complementary health insurance provides both special hotel services in case of hospitalisation and supplementary cover for benefits not included in the mandatory package.
- *Reputation and service quality.* Insurers can differentiate their offer by ameliorating service quality, for example improving staff availability and kindness, speed and accuracy of reimbursement procedures, tailoring of individuals' needs, information disclosure, and so on. Insurers can also invest in advertising, external communication and marketing in order to build image and reputation. Image will help them to retain clients and to attract people switching from other funds. While image and service quality are difficult to measure, they play a key role in differentiating an insurer from the others. Insurers with the same basic premiums will have a different power to retain clients depending on their image and service quality, although this is likely to raise their administrative costs considerably.

Table 6. Characteristics of different basic health insurance types

	Free choice of doctor	Premium	Level of co-payment
Ordinary basic health insurance	Yes	Ordinary premiums	230 CHF per year
Insurance with choice of deductible	Yes	Reduced premiums in proportion to the deductible level up to a maximum 40% reduction for an annual deductible of 1,500 CHF.	4 possible levels of co-payments: 400; 600; 1,200; and 1,500 CH.
Bonus Insurance	Yes	The premium paid in the first year is 10% higher than ordinary, then premiums are progressively decreased up to 45% after 4 years.	As in ordinary insurance
HMO insurance	Restricted to designated providers	Reduced premiums; premium reductions are fixed by the fund, up to 20% reduction.	As in ordinary insurance

Structure of the market

27. Choice of insurer may also be linked to the structure of the insurance market. The number of sickness funds surely influences choice, but also the size, the relative market power and the conduct of insurers on the market might have an effect. Insurers with a more pervasive distribution may be able to attract individuals because of their proximity to them.

3.5 The Swiss health insurance market

28. The Swiss health insurance market comprises a plurality of insurers. The number of sickness funds has been steadily diminishing over the years, going from 815 in 1980 to over 120 in 1998. All sickness funds provide voluntary cash benefits insurance and 109 were offering basic health insurance in 1998, while about half offered voluntary complementary insurance. Sickness funds have a mutual and non-profit character³⁷. They can assume a variety of institutional and juridical forms such as public or private law institutions, associations, foundations, cooperatives. Sickness funds can operate in one or more Cantons, and vary greatly in size. They include small units with less than hundred people and large sickness funds with over a million people (table 7). In some Cantons, sickness funds operate at municipal level. Profit-making private insurers operate only in the voluntary health insurance market, where about 56

37. Lehmann P., Gutzwiller, F. and Martin, J.F. (1989), page 27.

life and non-life insurers were providing individual and group health insurance in 1998. Private insurers also differ in size and in range of activities.

29. While the demand for voluntary health insurance can expand or shrink on the basis of purely competitive forces, the size of the basic mandatory health insurance market equals the number of residents in Switzerland because health insurance is taken on an individual basis. Over 7 million basic insurance policies have been emitted in 1998. Demand has been increasing at a rate of 0.4% per year since the introduction of the LAMal, reflecting changes in the resident population. Although greater variations may occur across the Cantons, each Canton is a mutually exclusive market because individuals' location decisions can be assumed to be neutral to insurers competitive policies.

Table 7. Sickness funds practising only basic health insurance, by size

Fund size (# of individuals insured)	% of sickness funds by fund size				% of individuals insured by fund size			
	1996	1997	1998	1999	1996	1997	1998	1999
> 1,000,001*	1.38	0.78	1.69	1.83	27.94	16.73	30.09	31.04
100,001-1,000,000	8.97	10.85	10.17	11.01	56.24	68.41	54.16	52.21
10,001-100,000	17.93	18.60	22.88	23.85	12.38	11.78	13.23	14.33
1,001-10,000	45.52	45.74	40.68	41.28	3.16	2.84	2.3	2.25
< 1,000	26.21	24.03	24.58	19.27	0.28	0.23	0.22	0.16
NA				2.75				
Total number of sickness funds and individuals	145	129	118	109	7,194,754	7,214,805	7,248,603	7,247,561

Source: Compiled from data communicated by OFAS

* This category normally includes two sickness funds. In 1997 one of them did not reach the one-million limit and was hence included in the second category. This explains why the 1997 value differs significantly from other years.

30. Mandatory basic health insurance accounts for two thirds of the overall market (figure 3). While ordinary health insurance constitutes the majority of the basic insurance contracts (72% of sickness funds premiums in 1998, table 8) new insurance forms are gaining ground, especially insurance with higher deductibles and HMO insurance. At the end of 1998, 6.8% of all people covered by basic health insurance were participating in an HMO arrangement. Bonus insurance is on the contrary chosen less frequently, representing less than 1% of the market (figure 4). Voluntary complementary health insurance consists of a range of benefits not included in the basic package. The market for voluntary insurance may shrink in the future because the LAMal has extended the range of benefits beyond those included into statutory health insurance under the LAMA. Although private insurers offer complementary health insurance, this market segment remains dominated by sickness funds, which cover around three-quarters of the market. Finally, voluntary daily cash-benefits insurance has a minor role: it accounted for less than 3% of all premium financing in 1998 and covered about 1.5 million people.

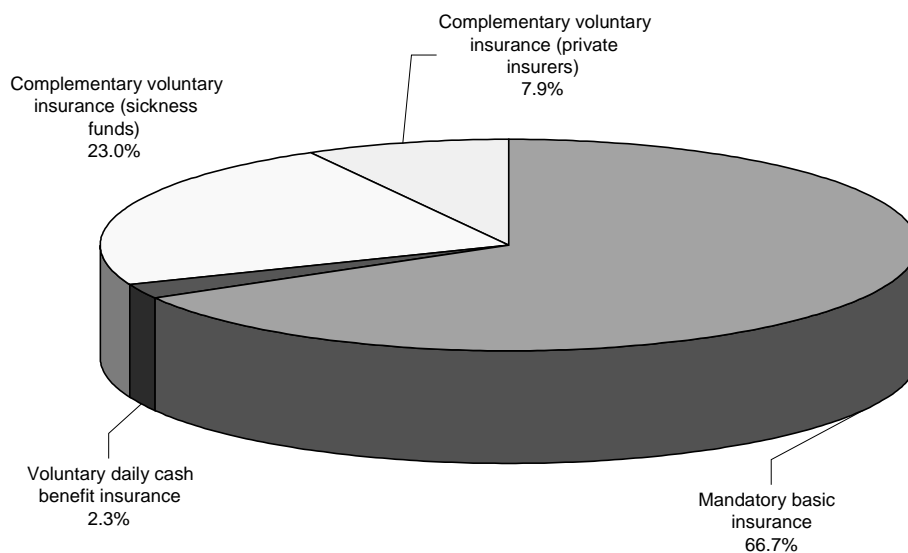
Table 8. Sickness funds financing* by insurance type, 1996-1998 (Million of CHF)

	1996		1997		1998	
Mandatory basic insurance	12,714	69.87%	13,703	71.21%	14,701	72.46%
Voluntary daily cash-benefit insurance	834	4.58%	559	2.90%	510	2.51%
Voluntary complementary insurance	4,649	25.55%	4,982	25.89%	5,079	25.03%
Total	18,197		19,243		20,290	

Source: OFS (2000a)

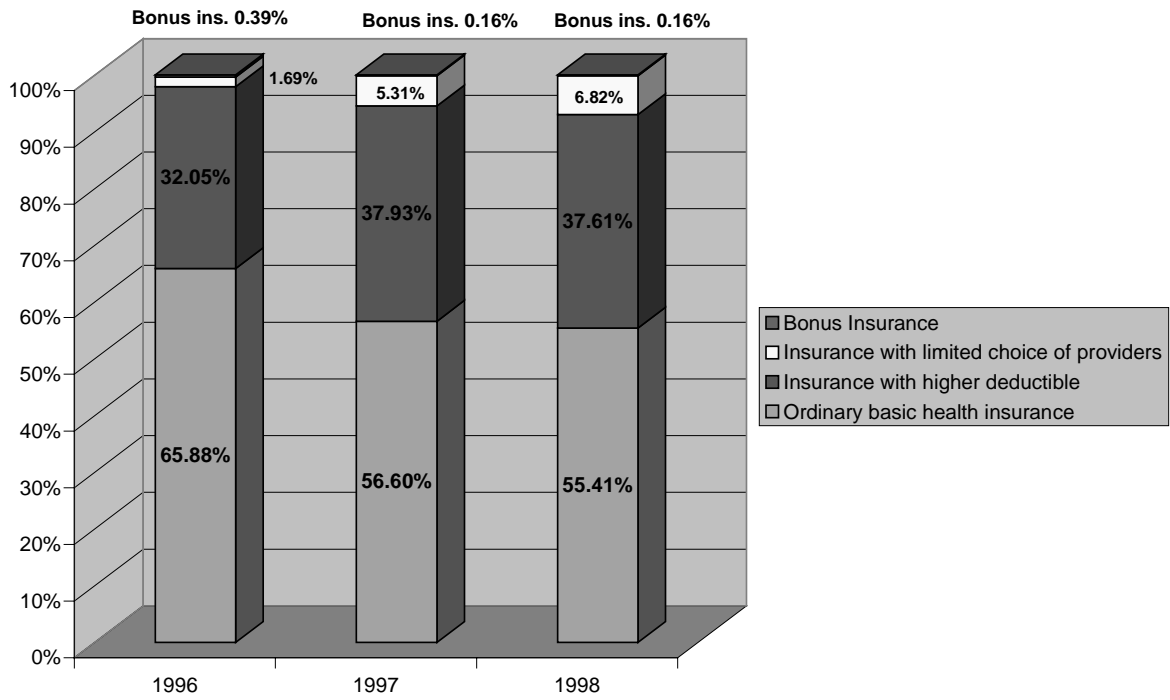
* Includes gross premiums and cost sharing; excludes subventions and self-financing of sickness funds

Figure 3. Health insurance financing by insurance type, 1998



Source: Compiled from data from OFAS (1999b) and OFAP (1998).

Figure 4. Individuals insured by basic health insurance type, 1996-1998 (end if year)



Source: Compiled from data from OFAS (1999b)

4. HOW IS INDIVIDUAL CHOICE OF INSURER WORKING?

31. Does the choice mechanism work in practice as envisaged in theory? This section gathers available evidence on the functioning of the system at three levels. First, it considers whether people actually choose sickness funds by reviewing switching data and it examines possible explanations of individuals' behaviours. Second, it explores the functioning of mechanisms to support individual choice, particularly whether choice occurs on an equal basis for all, whether the risk compensation mechanism functions effectively and whether people understand the choice mechanism. Third, it presents preliminary reflections regarding the fulfilment of initial goals: intensification of insurers' competition, creation of cost containment incentives for insurers and enhancement of individual liberty. This section utilises evidence from four main sources: a) administrative data and research reports of the Office Fédéral des Assurances Sociales; b) evidence gathered in focused interviews with the Office Fédéral des Assurances Sociales, the insurers' association, patients and consumers associations; c) preliminary tabulations compiled from an OFAS survey of individuals³⁸; d) articles and reports on the Swiss health insurance system. Once the problems that emerge in the current system are identified, section 5 gives some suggestions on ways to strengthen the system and issues for further investigation. However, the evidence gathered is limited in scope and preliminary in analysis and further evaluation is needed.

4.1 Individuals switching behaviours.

32. One main assumption behind the choice of insurer mechanism is that individuals switch freely towards better performing sickness funds. Assuming that the initial (1996) distribution of individuals across LAMal-insurers was not optimal, i.e. not all individuals were insured with the sickness fund offering the quality-price ratio that best matched their preferences, it could be expected that people would start 'shopping around'. A way to examine whether the choice mechanism works effectively consists in looking at people's switching behaviours and highlighting factors that affect choice of insurer. Preliminary results from an individual survey will be utilised to illustrate switching behaviours. While such data should be interpreted with caution, they shed light on individuals' choices and help formulate hypotheses about the motivations underpinning their behaviour.

38. The purpose of the insurees' survey was to analyse the effects of the LAMal, investigate whether individuals are satisfied about it, and how they obtain information about new health insurance arrangements. Survey data have been collected during the year 2000 across a statistically representative sample of Swiss households. Anonymous respondents were chosen randomly at two levels: first, a total of 2,152 households were randomly selected among all Swiss households; second, individuals were picked randomly among over-18 family members (one person per family).

Do people switch?

33. Few people seem to take advantage of the opportunity to switch freely across sickness funds, with typical switchers being young and healthy individuals³⁹. About 84.4% of the surveyed population has never changed fund since the introduction of the LAMal; moreover 88.2% does not appear to plan any switch in the future (table 9). Annual switching percentages are very low: on average only 3.9% of surveyed individuals switched in any given year (Table 10). People seem to have changed insurer especially in the early stages of the health insurance reform, with a peak of 5.4% in 1998, while switches have decreased steadily over the most recent years reaching a minimum of 2.1% in 2000. Data suggests that only 0.5% of the surveyed individuals might have changed sickness fund more than once, bringing the total number of switchers to 14.5% of the surveyed population⁴⁰. Switching is predominantly occurring at the beginning of any calendar year⁴¹.

34. Switching behaviour seems to be linked with age, health status and Canton but not with gender. In any given year, switchers seem to concentrate in the age group 26-40 (table 13), and among individuals with good or very good self-perceived health status (table 12). Finally, switching is more prevalent in French speaking Cantons, followed closely by the Italian speaking Canton (table 14).

39. Evidence on the limited number of switches derives from the OFAS survey of insurees, but is also contained in other studies. See for example: Beck, K. (1998); Beck, K. and Zweifel, P. (1998); Spycher, S. (1999a).

40. I.e., 313 people. The survey asked 2,152 individuals whether they switched insurer in 1997, 1998, 1999, 2000. A total of 323 switches can be tracked. Considering that 1,816 individuals affirm they never switched and that 23 individuals answered either "I don't know" or did not give any answer, 10 switches were recorded in excess of the number of people surveyed [(323+23+1,816)-2152]. It can be reasonably assumed that 10 people switched twice since 1996, as 'triple switchers' are very unlikely in such limited period.

41. *Message concernant l'arrêté fédéral sur les subsides fédéraux dans l'assurance-maladie et la révision partielle de la loi fédérale sur l'assurance-maladie*, 21 September 1998, page 27.

Table 9. Switching behaviours since the introduction of the LAMal

	Number of individuals	% of individuals
Never switched	1,816	84.4%
Planning to switch	57	3.8%
Maybe will switch	138	6.4%
Non planning to switch	1,899	88.2%

Source: OFAS survey of insured persons. N=2,152

Table 10. Annual switches since the introduction of the LAMal

	Number of switches	Switches (% of individuals)
Switch at the beginning of 1997	103	4.8%
Switch at the beginning of 1998	116	5.4%
Switch at the beginning of 1999	59	2.7%
Switch at the beginning of 2000	45	2.1%
TOTAL switches	323	15.0%

Source: OFAS survey of insured persons. N=2,152

Table 11. Switching behaviours by gender

	Number of switches since 1996	Number of individuals	Switches (% of individuals in same gender group)
Female	169	1,143	15.2%
Men	154	1,009	16.0%
Total	323	2,152	15.0%

Source: OFAS survey of insured persons. N=2,152

Table 12. Switching behaviours by health status

	Number of switches since 1996	Number of individuals in health status group	Switches (% of individuals in same health status group)
Very good	141	758	18.6%
Good	147	1019	14.4%
Average	31	281	11.0%
Bad	3	64	4.7%
Very bad	1	8	12.5%
TOTAL	323	2,152	15.0%

Source: OFAS survey of insured persons, N=2,152

Table 13. Switching behaviours by age group

	Number of switches since 1996	Number of individuals in the age group	Switches (% of individuals in same age group)
18-25	9	60	15.0%
26-30	55	162	33.9%
31-35	48	234	20.5%
36-40	56	286	19.6%
41-45	35	256	13.7%
46-50	35	227	15.4%
51-55	19	179	10.6%
56-60	23	191	12.0%
61-65	18	171	10.5%
66-70	13	162	8.0%
71-75	4	100	4.0%
76-80	3	81	3.7%
81-85	4	28	14.3%
86-90	1	14	7.1%
91 and over	0	1	0%

Source: OFAS survey of insured persons, N=2,152

Table 14. Switching behaviours by region

	Number of switches since 1996	Number of individuals in region	Switches (% individuals in same region)
German Cantons	187	1,443	13.0%
French Cantons	87	450	19.3%
Italian Canton	49	259	18.9%
TOTAL	323	2,152	15.0%

Source: OFAS survey of insured persons. N=2,152

Why people do (or do not) switch?

35. While there is no sufficient evidence to test what elements drive the choice of LAMal-insurer, preliminary survey results suggest that “negative” motivations play a far greater role in switching decisions than “positive” motivations. Individuals seem to be reluctant to switch and they do so if they are very dissatisfied with the bad performance of a fund rather than systematically look for a sickness fund with a better performance.

Non-Switchers.

36. People can be non-switchers for many reasons. A first category of survey responses suggests that some individuals can be thought as *passive non-switchers*, i.e., they could be very adverse to change, not sensitive to the insurer performance, or consider the costs of switching too high compared to the benefits. Up to three in ten non-switchers seem to stick to the same sickness funds for tradition, comfort with the status quo, or because they think that being insured elsewhere would not change things substantially (table 15). Switching may involve a change from something that is known to something that is uncertain. People might resist changing if they cannot foresee the outcomes of their choice, simply because they are non-risk

takers. Others may remain with a sickness fund because they are uninterested in comparative performance. Passive non-switchers are unlikely to engage spontaneously in a search for insurers with better performance. They remain with the current sickness fund unless some major performance shock makes them very unsatisfied with their initial choice.

37. A second large category of responses suggests that more than half of non-switchers might be sensitive to insurers' performance, although their behaviours do not fully support this hypothesis. As much as 35% of the responses confirmed that the performance of the current sickness fund is satisfactory to respondents, and an additional 11.4% ranked performance as good (table 15). Two in three survey respondents also ranked their degree of satisfaction with their sickness fund reimbursement procedures between 8 and 10 on a scale 1-10. While the good performance of the current sickness fund represents the most common reason adduced by non-switchers, this category of non-switchers could include both "informed non-switchers", who actively compare performance across insurers, and "uninformed non-switchers". Available evidence does not enable to distinguish individuals belonging to the two categories. It is nonetheless interesting to review their possible characteristics.

38. *Informed non-switchers* compare sickness funds performance and make a conscious choice not to switch. These non-switchers are perhaps more sensitive to quality than to price. In fact they seem to choose not to switch even if premiums have been raised, probably because they are more sensitive to non-price factors and their reserve price (the price at which they would choose to switch) is higher than the rise in premium they have faced since 1996. Moreover individuals seem to change features of their basic health insurance cover more frequently than they change sickness fund. The existence of various basic insurance products allows individuals to tailor their preferences, particularly with respect to price. Over recent years, insurance policies with higher deductibles have been growing at a faster rate than the number of individuals switching insurer. The same applies to HMO insurance (figure 4). This is confirmed by survey results. As many as 23.7% of the survey respondents reported that they changed the type of basic health insurance cover for at least one family member during the period 1996-1999, while only 3.9% of respondents switched annually in that period.

39. *Uninformed non-switchers* may include individuals satisfied with their current choice, who however do not necessarily compare performance across sickness funds. Some non-switchers might have developed a strong loyalty feeling unrelated to the actual comparative performance of sickness funds. The insurer's marketing ability might contribute to shape these individuals' opinion. Other uninformed non-switchers would perhaps switch if they found a better insurer, however they are uninformed about comparative performance or consider the cost of collecting this information too high in relation to switching gains. Switching is in fact a time consuming exercise that involves transaction costs on the side of individuals. Information on sickness funds performance is currently inadequate and not easily comparable (paragraphs 54 onwards). Better information might induce uninformed non-switchers to switch or conversely support their decision not to switch on a better-informed basis.

40. A third category of non-switchers might encompass individuals who do not manage to switch or think they cannot switch. While this represents only a minority of survey respondents, their answer is nonetheless an indication either of cream-skimming practised by sickness funds or ignorance about the possibility to switch on the side of individuals. Both hypotheses seem to find some validations (paragraphs 53-56).

Table 15. Reasons for not changing insurer (non-switchers only; more answers allowed)

Individuals not interested in LAMal-insurers' performance ("Passive" non-switchers?)	Number of responses	% of total responses
Habit, tradition	311	13.0%
Comfort	235	9.9%
It would be the same elsewhere	86	3.6%
Average sickness fund	33	1.4%
Personal knowledge of the fund manager/representative	10	0.4%
Remain for solidarity	10	0.4%
Proximity	6	0.3%
Individuals interested in LAMal-insurers' performance ("Informed" or "uninformed" non-switchers?)		
Satisfied with current solution	830	34.8%
Good performance	272	11.4%
Good ratio cost/benefits	210	8.8%
Good customer service	86	3.7%
Convenient premiums	67	2.8%
Slight increase in premiums	34	1.4%
Availability of other insurance products	7	0.3%
People who cannot change ("Uninformed" non-switchers or cream skimming?)		
Cannot switch	42	1.8%
Cannot change due to health problems	30	1.3%
Other	81	3.4%
Don't know or no answer	33	1.4%

Source: OFAS survey of insured persons.

Percentages refer to total responses obtained. Since individuals were allowed more than one answer, these percentages cannot be directly applied to the overall number of non-switchers (1,816 individuals, i.e. 84.6% of the survey sample). However, they might be considered as a low-accuracy proxy for the share of various categories of non-switchers.

Switchers.

41. Switchers seem to be motivated predominantly by price factors but non-price motivations, especially service quality, are also important. A large rise in premiums seems to motivate switchers in about one in four cases (table 16). Similarly, nearly one in five seems to have chosen another insurer on the basis of price. Switches seem to occur with a higher frequency in French-speaking Cantons, where on average premiums are more expensive than in German or Italian speaking Cantons.

42. While high premium levels are a major concern for individuals, the trend towards a general increase of premiums does not seem to stimulate many people to look for comparatively cheaper options at other funds. Many respondents think that basic health insurance premiums increased substantially (47.6%) or at least slightly (39.4%) following the introduction of the LAMal, thus suggesting that people are concerned about premium rises. Indeed most respondents (72.3%) say that they try to minimise the cost of their basic health insurance cover. However, individuals are rather reluctant to switch insurer, despite

persistent differences in premium levels between sickness funds in any given Canton. Individuals are likely to attempt to reduce the overall insurance costs by changing the basic health insurance type (paragraph 38).

* * *

43. By and large, individuals seem to prefer sticking to their initial choice of insurer, even when large performance variations, for example premium level differences, exist across funds. Many remain insured with a given sickness fund following the parents or friends choices (table 17), or seem uninterested in switching because their choice of insurer is informed by non performance-related factors such as tradition, family history and comfort. Other individuals seem to be satisfied with their current solution, but it is not clear whether they consciously choose to remain at a fund or they are unaware of better options. These insureds might not systematically compare sickness funds performance across insurers. Individuals seem to have a high reservation price, and look for alternative solutions only if confronted with a dramatic change, for example substantial premium raises, or a problem, for example greatly deteriorating quality. They also might prefer changing insurance type rather than switching. As to the few switchers, they seem to be sensitive to differences in premium levels and often were dissatisfied with the performance of before-switch sickness funds, although other factors might motivate their switching decision. Most of the switchers appear satisfied with their decision to change insurers (78%).

44. These results are consistent with similar international experiences. While in Germany people seemed overall to favour the introduction of competition across sickness funds, surveys carried out before and after switching was allowed⁴² revealed a greater importance of non-price factor⁴³. Overall, people believed that the introduction of competition across sickness funds would improve quality-price ratios (60%), while a smaller group disagreed (37%). The introduction of the opportunity to switch funds surely raised individuals' awareness of differences in price across sickness funds. While in 1993 up to 90% of the people interviewed did not know the level of contribution effectively paid to sickness funds, 29% alleged they would switch to lower-priced opportunities in 1996. However individuals interested in switching seemed to be more concerned with access to medical services, sickness funds responsiveness to requests for reimbursement and quality of administrative service than with the cost of medical coverage.

Is current switching too little or too much?

45. While the Swiss legislator might have foreseen a greater proportion of migrations, the currently small number of switches does not indicate in itself that the individual choice system is ineffective in sending market signals. Theoretically it only takes a few switches to generate demand signals at the margin, so the fact that only few people switch does not imply that the market is not made more contestable. Contestability arises from the fact that the position of an insurer can be challenged because sickness funds with better quality-price ratios can attract insureds from other sickness funds. This possibility needs only be theoretical, a prospect, and not real, a fact, to transmit market signals and thus challenge an insurer's market position.

42. The possibility to switch was introduced in 1996. Surveys were carried out in 1993 and 1996.

43. Wasem, J. and Güther, B. (1998).

Table 16. Reasons for switching sickness fund for switchers

	Number of responses	% of responses
Price factors:		
Large premium rise	105	26.4%
Expensive premiums/other fund with better premiums	68	17.1%
Bad ratio cost/benefits	27	6.8%
Non-price factors:		
<i>Products/ offer</i>		
Inadequate quality/other fund with better quality	35	8.8%
Offer not available	4	1.0%
<i>Unsatisfied, bad personal experience</i>		
Unsatisfied with current solution	15	3.8%
Bad experiences	14	3.5%
Worst than other funds	3	0,8%
<i>Customer service/availability</i>		
Bad customer service/other fund with better customer service	7	1.8%
Non personal knowledge of the fund manager/representative	3	0.8%
<i>Location</i>		
No proximity	5	1.3%
<i>Other</i>		
Don't know or no answer	33	8.3%

Source: OFAS survey of insured persons.

Percentages refer to total responses obtained from switchers. Since individuals were allowed more than one answer, these percentages cannot be directly applied to the overall number of switchers (313 individuals, i.e. 14.5% of the survey sample). However, they might be considered as a low-accuracy proxy for the share of various categories of switchers.

Table 17. Reasons for being insured at the current LAMal-insurer

	Percentage of respondents
Parents have always been there, friends/family advice	40.8%
Convenient premium	17.2%
Automatic procedure by an Authority	15.1%
Agent advice	5.4%
Info obtained from the media	1.3%
Other	21.7%

Source: OFAS survey of insured persons. N=2,152

46. Three issues need nonetheless to be considered to test whether the current low level of switching generates adequate demand signals. First, market signals might be and remain weak if individuals are insensitive to sickness funds performance. If this is the case, then individual choice is not the most effective way of stimulating performance improvements in sickness funds. The evidence seems to suggest that few individuals use switching as a tool for improving the performance of their sickness funds, though better investigation on the determinants of choice is needed to estimate individual sensitivity to sickness funds performance. Second, little switching might indicate ineffectiveness of the switching mechanism if individuals cannot exercise their choice freely. In this case it would be necessary to strengthen the choice

mechanism in order to facilitate the disclosure of demand signals. The next section assesses existing evidence over the effectiveness of mechanisms to support switching, while some recommendations over how to improve them are included in section 5. Third, even if market signals exist, sickness funds conduct might remain unaffected or even result in undesired market behaviours. This might occur for example if there are few tools sickness funds can exercise to improve performance or if demand signals cause them to compete on cream skimming. In this case, the important question would not be promoting more switching, rather ensuring that sickness funds can utilise better tools for improving their performance. Section 4.3 looks at the effects of switching on competition and at whether sickness funds dispose of tools for controlling costs better.

47. Too little switching might be sub-optimal, especially if it results from the inability of individuals to migrate easily across funds and if it is not sufficient to influence insurers' conduct. However excessive switching can also be sub-optimal. The experience with individual choice of pension fund in some Latin America countries is telling in this regard⁴⁴. When individuals had to choose among identical pension products that differed almost only in fee levels, they showed a very high sensitivity to pension funds advertising rather than to real comparative performance. Pension funds targeted aggressively potential clients and in so doing their administrative and labour costs (the cost of hiring new agents) increased substantially. While the level of switching was very high, neither significant benefits for individuals nor real efficiency gains for the system derived from such a high level of switching. Instead, higher costs for funds were converted into higher fees and contributions for individuals. Switching beyond a certain level might be sub-optimal if it increases total administrative costs beyond a feasible level of cost savings. Moreover high switching rates are not itself an indication that incentives are working properly, for example people may switch towards bad performers if their decisions are not properly informed, or they may switch for wrong reasons. This suggests that policies should not promote high switching levels as an absolute goal. Policy makers should rather assess what changes in insurers conduct result from individual migrations and whether these changes are desirable. This analysis will be continued in section 4.3⁴⁵.

4.2 Do mechanisms to support free choice of insurer work satisfactorily?

48. Some individuals might refrain from switching insurer because the choice mechanism does not work as originally envisaged. Competitive insurance markets can generate three major market failures that inhibit individuals' freedom of choice. Insurers may adjust premiums on the basis of individuals' conditions existing prior to joining the scheme. They may purposeful select low-risk cases in order to limit their risk exposure. And individuals might be handicapped in their switching choice because of asymmetric information between individuals and insurers regarding insurers' performance. Although the Swiss regulator has introduced mechanisms to face each problem (as described in section 3.3), their effectiveness might not be sufficient to ensure that all individuals can switch on an equal basis. Indeed existing evidence suggests the presence of switching problems for some individuals. Three issues are relevant:

- Can all individuals switch on an equal basis regardless of their risk status and incomes?
- Is the risk compensation mechanism effective in reducing cream skimming incentives?
- Is adequate, cheap and reliable information available to support choice?

44. Queisser, M. (1998).

45. There is theoretically an optimal level of switching across sickness funds, which will depend on the balance between the additional administrative costs of switching and the possible savings entailed by switching.

Risk adjusting and means-tested subsidies.

49. Individuals can choose insurer irrespectively of differences in income and health risk if there is cross-subsidisation across different risk and income groups. For this purpose, the Swiss system prohibits sickness funds from risk adjusting and subsidises low-income individuals.

50. Some evidence indicates nonetheless that sickness funds can *risk adjust* indirectly. About 3 in 10 survey respondents affirm that sickness funds can adjust premiums to age, suggesting either that people might not understand the new health insurance law, or that some possibilities to adjust indirectly premiums to risk exist. Sickness funds can risk adjust indirectly if they tie the conditions of a complementary insurance cover to the possession of a basic health insurance contract at the same fund, whether this occurs explicitly or out of the supervisory agency sight. Immediately after the introduction of the LAMal sickness funds could oblige individuals switching basic insurer to end their complementary insurance contracts⁴⁶. While such practice is now expressly forbidden⁴⁷, interviews with consumers associations suggest that some people continue to experience similar problems. Many people complained that reimbursement times deteriorated after they separated basic health insurance and complementary health insurance in two different sickness funds. Such separation is in addition very impractical because doctors and hospitals do not prepare separate bills for services included under the two different covers. Finally, premiums for complementary health insurance can be more expensive if people are not insured by the same fund for basic health insurance. Bad risks may face a substantial premium increase if they switch sickness funds for basic or complementary insurance, which may discourage them from switching altogether.

51. Low-income individuals might not enjoy the same opportunities to switch as richer individuals unless two conditions are satisfied: a) means-tested subsidies are well targeted; and b) information on eligibility to income-compensation is easily accessible to all needy individuals. Means-testing procedures and eligibility criteria are fixed locally and differ widely across Cantons (section 3.3). The lack of a standardised means-testing framework throughout the Confederation reflects the Swiss principle of subsidiarity in social policy⁴⁸. In order for the choice mechanism to function smoothly for all Swiss residents, the two conditions need to subsist in all Cantons. While no exhaustive information is currently available on the effectiveness of subsidisation on a Canton by Canton basis⁴⁹, including errors in targeting, existing evidence seems to suggest that individual behaviours do not significantly vary with family income⁵⁰. Nonetheless consumers associations report that information on eligibility procedures for subsidies might not be accessible to all persons in all Cantons.

46. Ombudsman (1996 and 1997).

47. *Message du 21 Septembre 1998 concernant l'arrêté fédéral sur les subsidies dans l'assurance-maladie et la révision partielle de la loi fédérale sur l'assurance-maladie.*

48. According to the principle of subsidiarity, Cantons responsibilities in social policies extend to all areas but those explicitly stipulated by the Federal constitution as Federal responsibility. OECD (1999), p. 130.

49. Although there might be a cultural component in the decision to apply for a subsidy, it is puzzling that in the period 1996-1999 French and Italian speaking Cantons have utilised 100% of available resources, while the use of allocations in German speaking Cantons varied from 50% to 97% (OFS, 2000a, page 52). It might be worth investigating whether the reasons behind such behaviour are linked to cultural factors, differences in the targeting process, or the availability of information on eligibility across Cantons.

50. Personal communication from OFAS, 21 March 2001.

The risk compensation mechanism and cream skimming

52. Despite the existence of a risk compensation mechanism, incentives for cream skimming are still relatively high. One of the aims of the risk compensation mechanism is indeed to eliminate such incentives. The Swiss risk compensation system is based on demographic factors, namely sex and age of people insured, which have a limited capacity to account for differences in effective risk⁵¹. While the existing data collection structure does not enable to calculate risk compensation on the basis of more sophisticated systems such as for example hospital costs, the current mechanism creates risk selection incentives⁵². Since the funds with worse-than-average risk are not adequately compensated for their higher medical costs, sickness funds face incentives to select individuals in good health. Such incentives are even greater considering that the majority of individuals purchase basic and complementary insurance at the same sickness funds. As insurers can make profits in the provision of complementary health insurance, they have incentives to attract and retain good risks, especially when these people buy a complementary insurance together with the basic cover.

53. While only 10% of the surveyed sample think that insurers can choose the individuals they prefer to insure, with a slight predominance of women (13.8%) compared to men (8.2%), available evidence suggests that risk selection is indeed taking place⁵³. Some sickness funds have impeded people from switching insurers, tried to persuade bad risks to switch, or even refused cases, thus violating the legal requirements of the LAMal⁵⁴. This is confirmed by the results of a study involving selected interviews with sickness funds⁵⁵, and it has also been reported by other organisations⁵⁶. Sickness funds can assess accurately individual risks through the questionnaire compiled when individuals buy a complementary health insurance, in cases where individuals buy both insurance covers. They can indirectly discourage bad cases and segment individuals according to risk by reducing service quality selectively, delaying reimbursements, reducing information disclosure and deteriorating customer assistance. Sickness funds can also seek to attract good risks, for example insurance agents and brokers can aggressively target selected risks groups. The extent of these phenomena is however difficult to quantify.

Information

54. Individuals do not always seem to make choices on a well-informed basis. Although various organisations provide guidance on the LAMal⁵⁷, the information currently available to individuals does not seem to be adequate. First, not all individuals understand the new health insurance law. Some people may think that sickness funds can risk adjust and cream skim because they are ignorant about the differences between the LAMal and the LCA regimes, or they are generally uninformed. According to reports made to consumers' organisations, some individuals are unaware of the possibility to switch freely, they think that they cannot split complementary from basic insurance, or they believe that the advantageous conditions

51. Beck, K. and Zweifel, P. (1998). Van Vliet, R. (1992). Gerdham, U., et al. (1998). OFAS (2000b).

52. This has also been reported by Spycher, S (1999a).

53. Beck, K. and Zweifel, P. (1998). Spycher, S (1999a).

54. *Message du 21 Septembre 1998* (ibid), pp. 26-28. Till, B. (1999), p. 202.

55. Spycher, S (1999a), page 12.

56. Three organisations have been interviewed: the Swiss Patient Organisation; the Romand Federation of consumers; and the Ombudsman de l'assurance-maladie sociale.

57. These include OFAS, patients and consumers organisations, the Ombudsman de l'assurance-maladie sociale, and the Concordat des assureurs-maladie suisses.

applied to basic health insurance will also apply to supplementary health insurance⁵⁸. Second, not all people make an informed switching choice. Information on comparative sickness funds conduct is difficult to gather. There are currently no ratings of insurers' performance, and about one in five switchers decided to change insurer on the basis of personal communication from relatives or friends (Table 18). Third some means of communications, such as sickness funds newsletters, do not seem the most effective information source on premium changes, and there have also been delays in communicating new premiums⁵⁹.

55. Information is also not cheap to collect. Information on premium levels is available to individuals however comparing premiums is a complicated and time-consuming exercise. A great variety of premium differentiations exist for a supposed 'unique' premium level. Sickness funds can stratify premiums into three regions within any Canton of operation, however the boundaries of the regions were not initially standardised and each sickness fund could define its own⁶⁰. A further complication is that premiums for special basic health insurance products or for holders of an accident insurance are expressed as reduction on ordinary premiums rather than as absolute numbers. In addition, while sickness funds are obliged to communicate any increase in absolute premium levels, there has been some confusion regarding communication requirements in case of changes in reductions on ordinary premiums. Only recently did information disclosure for all premiums become mandatory⁶¹. Finally almost a fourth of the switchers obtained information through a direct request to sickness funds. While information gathered in this way will likely satisfy individual needs, this way of collecting information is costly.

56. Last, the relative importance of various information sources suggests that not all individuals have access to general and evenly distributed information. About 25% of all switchers obtained wide-distribution information from newspapers, the radio, or OFAS, compared to about 57% who received information from more personalised channels such as family, brokers, or direct enquiry to sickness funds. A more widespread availability of objective and transparent information would help individuals who are planning to switch.

Table 18. Source of information for switchers before the switch

Source	Percentage
Information directly requested from other sickness funds	24.3%
Relatives, friends	20.1%
Other	19.5%
Newspapers	17.9%
Brokers, agents	12.5%
Patients or consumers organisations	8.9%
No information	7.7%
Radio	4.1%
OFAS	2.9%
No answer	2.2%

Source: OFAS survey of insured persons. N=313

58. A research carried out by OFAS also supports the hypothesis that individuals are not well informed. See OFAS (1999a).

59. Ombudsman (1996), pp. 7-8 and Ombudsman (1997), pp. 5-6.

60. A revision of the LAMal, approved during spring 2000, established that regional boundaries should be defined by OFAS uniformly across sickness funds.

61. *Message du 21 Septembre 1998* (ibid).

4.3 Effects of the choice mechanism

57. This section assesses whether the goals underpinning the choice of insurer mechanism seem to be being met. Issues discussed are:

- Intensifying competition across LAMal-insurers.
- Creating cost-containment incentives for LAMal-insurers.
- Strengthening individual liberty.

Competition among LAMal-insurers

58. The 1994 reform aimed at encouraging full price and quality competition in the basic health insurance market. However, there is currently not much confirmation that such form of competition has been established. Price competition seems still weak, while quality competition is difficult to monitor. Rather, the available evidence suggests that competition via risk selection may be continuing to take place.

59. In a perfect health insurance market with community-rated premiums at each fund, homogeneous benefits and no switching costs, individuals would migrate towards the sickness funds offering lower premiums. Assuming that sickness funds have to accept all, such migratory process will eventually equalise differences in risk across sickness funds thereby levelling cost and premiums down. Insurers would compete on efficiency, a 'healthy' and desirable competition because it guarantees efficient sickness funds a competitive advantage over others, driving inefficient insurers out of the market. A risk selection strategy would not be rewarding: a reduction in insurers' medical costs due to risk selection would reduce premiums below the Canton average, and migrations would continue until risk differentials are again equalised. However, reality seems to differ from this stylised model.

60. *Price competition* does not appear to have intensified enough to cause a convergence in premiums across sickness funds. Although premium levels have shown a slight tendency to homogenise⁶², it is not known what proportion of such convergence can be explained by competitive pressures as opposed to regulatory measures⁶³. It seems, nonetheless, that competition among LAMal-insurers is not producing the desired effects. First, there is still a large divergence between the maximum and the minimum premiums charged within Cantons (the maximum premium being in many Cantons more than double the minimum premium). Second, premium dispersion has remained high in all Cantons and there is no clear-cut evidence of a continuing compression trend⁶⁴. Third, the evolution of insurers' costs does not support the hypothesis that premiums might eventually converge. The proportion of individuals insured at sickness funds with costs around the Swiss average, after removing the effects of federal measures, has decreased from 75% in 1992 to 62% in 1997⁶⁵, suggesting a lack of homogenisation.

61. Three main factors can explain why premiums are not converging: a) consumers' reluctance to switch; b) risk structure not equalising across sickness funds; c) cost structure not equalising across sickness funds.

62. Spycher, S. (1999a). Op. Cit., p. 11.

63. Two regulatory measures are prominent. A) An emergency Federal decree, effective during 1993-1995, forced sickness funds with higher-than-average premiums not to raise these. This might have contributed to a 'catching-up effect' from funds with lower premiums. B) The risk compensation mechanism, discussed further below, might be responsible for a slight premium equalisation across funds.

64. OFAS (1998a), p. 124-125.

65. Spycher, S. (1999a). Op. Cit., p. 12, Figure 3.

62. **Consumer reluctance to switch.** The reluctance of individuals to change insurer is likely to allow sickness funds with higher premiums than Canton average to maintain market shares without facing strong competitive pressures to reduce premiums. This market power could be partially explained by the ability of sickness funds to differentiate their product from the competitors⁶⁶ through improved quality which, while desirable, is nonetheless difficult to measure and currently not entirely visible to individuals. Information asymmetry is likely to reduce the effectiveness of demand signals and create incentives for sickness funds to increase premiums beyond levels justifiable with differentials in quality. On one side information asymmetry reduces individuals mobility, and on the other side it increases opportunities for insurers' rents, either in the form of inefficient operations, or in the form of higher reserves. This insurers' conduct is hard to detect because of the complexity of measuring quality differentials across funds. Given current switching behaviours and the possibility that people might not be making fully informed choices, it is nonetheless difficult to conclude that switching is sending effective market signals resulting in greater contestability of the market on quality-price ratios

63. **Risk structures.** A second explanation of wide premium dispersion is that risk structures are not equalising across sickness funds⁶⁷. Considering that only a few good-risk individuals seem to switch, lower-proportion funds systematically incur lower medical expenditures than higher-proportion funds. The risk compensation mechanism currently in place is only partially effective in promoting solidarity across insurers. This is because the mechanism is calculated only on the basis of demographic variables that have a low predictive power in explaining differences in individual health expenditures.

64. The combination of historical differences in risk structures, low migration rates, and only partially effective risk equalisation maintain incentives for sickness funds to cream skim. Competition on the basis of risk selection is 'unhealthy', for two reasons. First, it does not encourage quality and efficiency improvements. Second, it may drive sickness funds with the worst risk structure out of the market. The basic health insurance market has continued to see a decreasing number of sickness funds even following the introduction of both the LAMal in 1996 and of the risk compensation mechanism in 1993 (figure 5 and 6). Such concentration trend might be positive because it facilitates a more effective pooling of contributions in larger sickness funds⁶⁸. However, no efficiency gains will be achieved if concentration is favoured by an ineffective risk compensation mechanism, because any compensation system is administratively costly and might additionally discourage efficient and responsive sickness funds. No information enables at present to distinguish market exits resulting from price and quality competition from those induced by unfair competition across sickness funds.

65. The case of Visana is emblematic in this regard. Visana, one of the four largest insurers in Switzerland, exited basic health insurance activities in 8 Cantons in 1998 because premiums had become too expensive⁶⁹. While this decision might reflect inefficient operations or risk selection carried out through a location strategy, it might also have resulted from higher structural costs due to an ineffective compensation of risks. A more thorough investigation into the determinants of structural changes in the health insurance market could help understand the factors underlying the concentration process, whether differences in efficiency or in risk structures are the main cause.

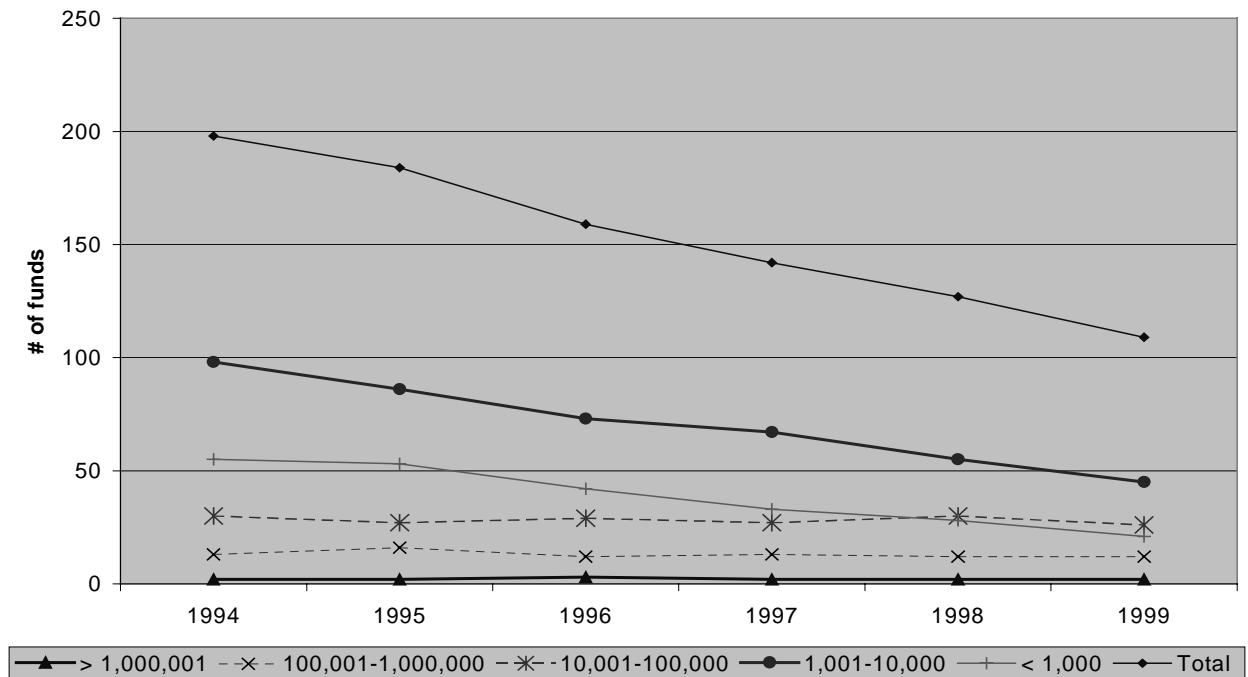
66. Through product differentiation, sickness funds might better tailor their offer to different market segments or even concentrate on a specific market niche. In exchange, individuals would be willing pay a premium on price.

67. Spycher, S. (1999a); Beck, K. (1998); Beck, K. and Zweifel, P. (1998); Zweifel, P. (2000); Spycher, S. (1999b).

68. In fact the financial viability of sickness funds increases with economies of scale in administering financial and organisational resources. WHO (2000), p. 103.

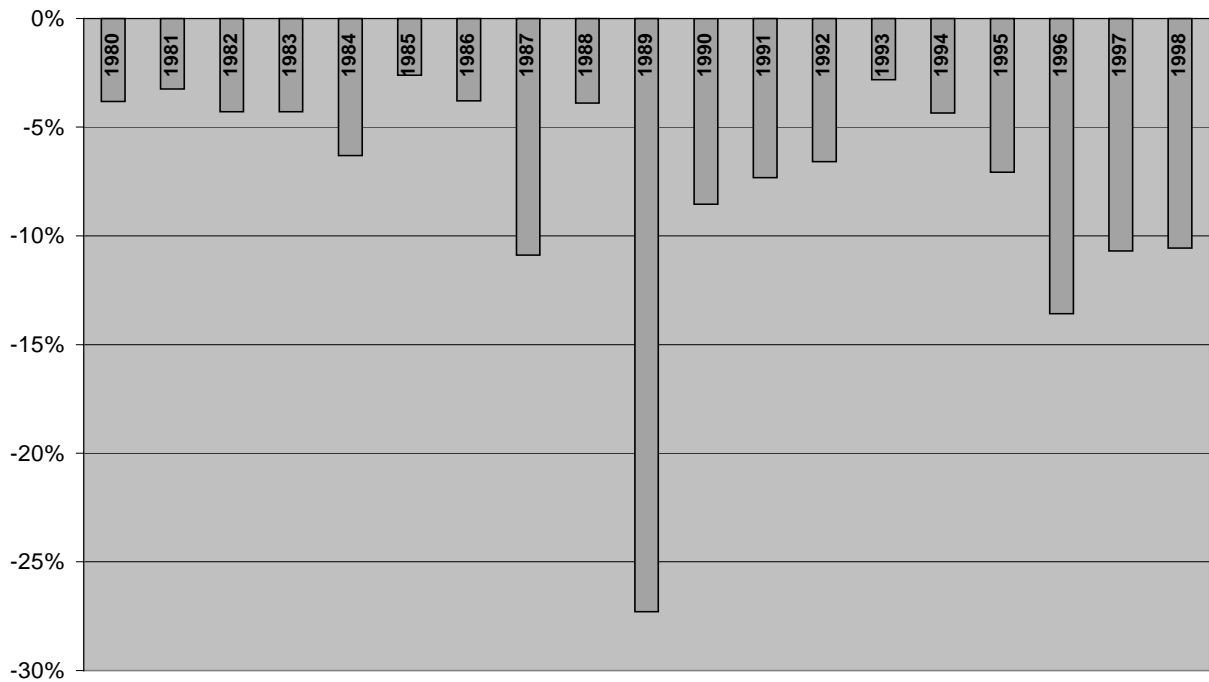
69. Ombusman (1998), p. 6.

Figure 5. Sickness funds operating in Switzerland by number of people insured



Source: OFAS data

Figure 6. Change in the number of sickness funds operating in Switzerland



Source: OFAS (1999b)

66. Although various proposals have been advanced to remove the distortions of competition induced by the present risk compensation mechanism, all seem to agree that abolishing the mechanism in 2006 is not desirable⁷⁰. While the current system is only based on few risk factors and equalisation of risk structures is far from occurring in practice, incentives to cream skim can be mitigated if even the current compensation system is maintained after 2006. Since a sickness fund has no guarantee that good risks will remain such (or bad risks will not turn into good ones), the opportunity cost of selecting risks increases as a function of the time frame considered by the insurer. If the risk compensation mechanism is maintained, it becomes difficult and costly for sickness funds to estimate the long-term variance of individuals' health expenditures with a greater degree of accuracy than the current compensation mechanism. Therefore sickness funds would have fewer incentives to risk select.

67. **Cost structures.** Finally, premiums might not converge because of differences in cost structures other than those resulting from differences in risk structures. To be competitive and reduce premium levels, a sickness fund can either reduce reserves or seek to reduce medical and administrative costs. The legislator established legal requirements in terms of the minimum reserve ratio (i.e. the ratio between reserves and premiums) that sickness funds have to maintain. Between 1994 and 1998, reserves have not been reduced neither in absolute value nor in per capita terms (table 19). As to medical and administrative costs, the lack of homogenisation already observed (paragraph 60) could be attributed to two factors, besides variations linked to risk structures:

- Sickness funds do not possess tools to contain medical costs. Insurers do not compete on cost-reducing strategies because they cannot exercise control over suppliers, in a country where medical utilisation is greatly supply-induced⁷¹.
- The current risk equalisation system does not maximise the incentives for sickness funds to control medical costs because it compensates medical costs retrospectively, i.e., on the basis of actual costs rather than predicted costs per age/sex group.

Table 19. Reserves of LAMal-insurers

	1994	1995	1996	1997	1998
Reserves (million of CHF)	3,986	4,080	4,008	4,017	4,118
Variation from previous year (%)	8.3	2.4	-1.8	0.2	2.5
Reserves per insuree (CHF)	507	509	495	514	531

Source: OFAS (1999b).

Cost containment

68. Since LAMal-insurers cannot make profits on basic health insurance⁷², the only scope for reducing premiums is to implement measures to contain costs. Although at aggregate level it would be hard to estimate the impact of individual choice on health expenditures (see figure 1, table 20 and 21), insurers' conduct can tell a lot about the impact of the choice mechanism on insurers' cost containment measures. Two main categories of costs can be distinguished: medical costs and non-medical expenses. The individual choice mechanism does not seem itself to generate any reduction of medical costs, and the impact of switching on administrative costs is ambiguous.

70. Beck, K. and Zweifel, P. (1998). Spycher, S. (1999a); Beck, K. (1998); OFAS (2000b); Spycher, S. (1999b).

71. The over-supply of both doctors and medical facilities (hospital and ambulatory care) has been considered one of the main factors behind health care costs escalation in Switzerland (OECD, 2000).

72. Profit-making is forbidden by the law.

Table 20. Cost structure of LAMal-Insurers (million CHF)

	1994	1995	1996	1997	1998
Medical benefits	15,273	16,157	17,444	17,647	18,469
Administrative costs	1,208	1,288	1,520	1,563	1,588
Other costs ⁷³	967	396	-227	651	710
TOTAL LAMal-insurers costs	17,448	17,841	18,736	19,861	20,766
TOTAL Health Expenditures	33,817	35,050	36,959	38,044	39,527
Total LAMal-insurers cost (% THE)	51.6%	50.9%	50.7%	52.2%	52.5%

Source: OFS (2000a). Cost refer to all insurer's cost and not only the costs of basic health insurance.

Table 21. Evolution of insurers expenditures (year-to-year percentage changes)

	1994-95	1995-96	1996-97	1997-98
Medical benefits	5.79%	7.97%	1.16%	4.66%
Administrative costs	6.62%	18.01%	2.83%	1.60%
Other costs ⁶⁹	-59.05%	-157.32%	-386.78%	9.06%

Source: Elaborated from OFS data (OFS, 2000a)

69. There are two main ways insurers can reduce their *medical costs*: by encouraging a reduction in the quantity of medical services consumed and by negotiating more advantageous reimbursement conditions with patients and providers.

70. Quantity consumed. A sickness fund can reduce the per capita medical consumption of the individuals it insures either by selecting good risks, who will need fewer medical services, or by inducing individuals and doctors to be more conscious about the consumption of medical services.

- Risk selection has already been described as an undesirable practice from a solidarity perspective and from the perspective of creating fair competition across insurers. On top of this, risk selection does not entail a reduction in medical costs at aggregate level but only a redistribution of these costs across different sickness funds. In the current system, insurers with a better-than-average risk structure can foresee savings on medical costs, because the compensation they pay reflects only partially the advantageous risk position. Nonetheless such medical cost savings are exactly equal to the cost increases sustained by sickness funds with a worse-than-average risk structure. The net effect on total medical costs is nil.
- Sickness funds can induce individuals to consume less by encouraging them to buy particular basic health insurance products. Bonus insurance and higher-deductibles insurance shift the risk of future medical expenses from the insurer to the individuals. Insofar as these individuals claim fewer medical expenses, promoting these products might indeed reduce sickness funds' medical costs. Such strategy might hence be cost-reducing for insurers. However, medical costs will shift to private pockets in the form of greater cost-sharing. At aggregate level cost savings will occur only if the cost reduction of insurers is higher than cost-shifting to individuals. While the cost containment effect of such demand-side measures remains debatable⁷⁴, potential reductions in aggregate medical consumption could not be

73. Other costs include modifications in reserves, the net effects of reinsurance and the risk compensation mechanism, and operating profits or losses.

74. Kutzin, J. (1998). No available estimates enable to draw conclusions on the cost containment effect of cost sharing in the Swiss case.

attributed to the effect of demand signals through individual choice of insurer. This is because: a) all funds offer insurance with higher deductibles at standardised conditions, hence this insurance type does not affect individual choice of insurer; b) bonus insurance accounts for less than 1% of the basic insurance market and the availability of this product does not seem to influence individual choice of insurer.

- Sickness funds can reduce the quantity of medical services consumed by promoting a greater role for doctors as gatekeepers. This might happen, for example, through managed care arrangements. The Swiss experience with HMOs indicates the possibility to realise real medical savings⁷⁵. Savings on medical expenditures might then occur when insurers offering HMO arrangements manage to attract individuals. However managed care options still account for a minor share of the insurance market. It is uncertain whether attracting individuals to this type of insurance product is convenient for sickness funds, because of the perverse effects of the current risk compensation mechanism. One study suggests in fact that insurers can pay more compensation for an individual (good risk) who buys a special basic insurance contract such as HMO than it would receive as premium from him/her⁷⁶. If this were the case, insurers would not willingly implement strategies to attract individuals to HMO arrangements, even though this might have positive cost containment effect at aggregate level. More evidence is needed to support this assumption.

71. Medical services reimbursement rates. Sickness funds can reduce their medical costs by obtaining cheaper tariffs than competitors from service providers. However funds are currently not in the position to negotiate special contractual relationships with providers. The law obliges all LAMal-insurers to contract with any service provider, and reimburse them on the basis of fees stipulated between insurers' and providers' associations. While the elimination of the legal obligation to contract with all at uniform tariffs has been under discussion, the impact of such a measure on medical costs is controversial. Supporters argue that it will enhance competition among insurers and enable them to conclude better contractual arrangements with providers, thus reducing medical costs⁷⁷. Arguments against include the increase in administrative costs entailed by individualised negotiations, and the possible repercussions on quality, as insurers might prefer low-cost providers to good-quality providers. Also, the potential cost containment effects of removing the obligation-to-contract at agreed prices have to be compared with the potential of other cost containment measures⁷⁸.

72. If the individual choice mechanism were to deliver any reductions in cost under current conditions, these would mainly have to come from reduced *administrative costs*. However switching creates rather than reduces costs. While no study of the impact of individual choice on sickness funds administrative costs exists for Switzerland, there is some evidence to suggest that efficiency gains are not materialising. After a steep increase in administrative costs between 1996 and 1998, probably due to the enormous changes in the health insurance system produced by the LAMal, total administrative costs

75. OFAS (1998b). This report presents the results of a research carried out during 1991 and 1994 on the new basic health insurance products (HMO, bonus insurance, insurance with choice of deductible). In the observation period, it was mainly good risks that purchased HMO insurance. Not surprisingly, then, the per capita medical costs of individuals with HMO arrangements were lower than the insurees average by 30-35%. However the study calculated that the per capita medical costs were much lower than could be expected only accounting for differences in health risk between HMO insurees and the average sickness fund insuree. As a consequence, the study suggests that a fraction of these cost savings could be attributed to the managed care product.

76. Spycher. S. (1999a).

77. Concordat de l'assurance-maladie sociale (CAMS).

78. For example, the introduction of new financing methods for hospitals such as global budgets.

consolidated at 7.6% in 1998, compared to 6.9% before the introduction of the LAMal in 1994⁷⁹. While it is difficult to make assessment on the various determinants of administrative costs, individual switching is not cost-free for sickness funds. Rather, switching is likely to drive the administrative costs of dealing with individual insurance policies up, as is confirmed by reports on sickness funds' difficulties in dealing with switching requests⁸⁰. Assuming that 4% of the population would switch on an annual basis, a break-even between switching costs and switching savings could be reached if savings accounted for at least 10% of administrative costs⁸¹. While more information on the variations of switching costs and switching savings in relation to number of switches is needed, this represents nonetheless a considerable percentage of switching savings to be attained before reaching break-even.

Individual liberty

73. One main aim of the switching mechanism is to empower individuals and enhance their capacity to choose. Individual choice has an intrinsic value arising from the possibility for individuals to express their preferences freely. Whether this objective is satisfied depends on the real opportunities for individuals to express their preferences and whether they understand the choices they have. Evidence already presented suggests that the choice of insurer mechanism might not function well for all, particularly for bad risks, and that information is not always adequate to support informed choices. Furthermore, individuals trying to exercise choice have experienced obstacles, such as sickness funds delays, lack of prompt communication, overlaps in insurance coverage at 2 sickness funds during the switching process, difficulty in separating basic from complementary health insurance and various other impediments⁸². While such difficulties might diminish as sickness funds and individuals become more familiar with the system, there is a risk that individuals are not sufficiently assisted in their choice. The mechanism supporting individuals' choice (section 3.3) might need to be strengthened further.

79. OFS (2000). Op. Cit., Table T3.2

80. Ombudsman de l'assurance-maladie sociale. *Rapport d'activité 1998*. Lucerne. Page 6-8.

81. Per capita administrative costs for *basic* health insurance averaged 115 CHF in 1998. Switching costs have been estimated in the range of 300 CHF to 800 CHF per switch (Spycher, S. (1999). Op. Cit. Page 16). These represent respectively 12 CHF and 32 CHF on a per capita basis (assuming that 4% of the population switches on an annual basis). The per capita switching costs, 12 and 32 CHF, account respectively for 10% and 28% of per capita administrative costs (115 CHF).

82. Ombudsman de l'assurance-maladie sociale. *Rapport d'activité 1996*. Lucerne. Page 7-8. *Rapport d'activité 1997*. Lucerne. Page 5-6.

5. DISCUSSION AND CONCLUSION

74. The new Health Insurance Law (LAMal) introduced major changes in the structure and organisation of basic health insurance in Switzerland, among which was the establishment of a system of freedom of choice of insurer. The thrust of the reform was to increase solidarity in health insurance while at the same time enhancing choice among individuals and ‘healthy’ competition among insurers.

75. The LAMal is an interesting and ambitious reform, perhaps unique within OECD countries. Its effort to combine competition and choice with solidarity is admirable and surely represents an improvement from the shortcomings of the 1911 legislative framework. Nonetheless, the experience of Switzerland shows how difficult it is to make such system work in the practice. Effective competition across fragmented financing pools requires regulatory interventions to steer insurers towards competition on quality-price ratios and away from competition using cream skimming. This is a complex task, and more research is needed to learn what regulation is most effective to achieve these goals.

76. While this paper has focussed on the choice of insurer mechanism without evaluating the LAMal in its entirety, some interesting conclusions concerning the functioning of the reformed system emerged:

- Few people switch LAMal-insurer. Switchers mainly consist of young people, who are by and large good risks.
- People prefer to change their basic health insurance type rather than change insurer, as suggested by the change in the mix of basic insurance types over the past few years.
- Non-switchers include people who may not be sensitive to the comparative performance of sickness funds as well as individuals who might be uninformed or consider the cost of switching greater than the benefits accruing to them.
- The mechanisms to facilitate free choice of insurer may not be functioning very effectively. It seems that especially bad risk individuals cannot switch as easily as good risks. While cream-skimming and risk-adjusting are prohibited by law, insurers can select preferred risks indirectly by influencing decisions to join an insurer⁸³ or to leave an insurer⁸⁴. Information to support choice seems somehow inadequate and costly to gather.
- Competition on price and quality has not been firmly established. Moreover, the system incorporates some perverse incentives that may encourage ‘unhealthy’ competition based on risk selection.

83. E.g., by advising high-risk individuals to enrol with a different insurer; attracting good risks through selective advertising and targeted mailing; offering appealing complementary insurance options to good risks if they buy both basic and complementary health coverage.

84. E.g., by providing poor service to bad risks, for example delaying reimbursements and deteriorating customer assistance; by reducing information disclosure to bad risks; by refusing to reimburse bad risks for border-case services not clearly included in the LAMal benefit package.

- Under current conditions, insurers have limited possibilities to introduce cost-reducing practices. In addition, the system might offer negative incentives to insurers to be efficient and reduce costs (as could be the case of HMO insurance).

77. These findings suggest that some features of the individual choice system need to be reinforced to make it functions better, and also suggest that the initial legislative goals are not entirely being met.

Strengthening the individual choice mechanism.

78. Strengthening the individual choice mechanism could facilitate individuals' switching decisions. Three main aspects could be considered: a) information disclosure; b) the elimination of cream skimming incentives for insurer; b) the clear separation of LAMal coverage from complementary insurance.

A) Information disclosure

79. Better access to information could help individuals deciding to switch insurer.

- i) Many people seem not to understand all the feature of the reformed basic health insurance system. The distribution of information to the general public, including information campaigns, communication on any legislative revision made to the LAMal, and information on patients' rights and means to obtain consumer protection could contribute to filling this gap.
- ii) Individuals collect information on basic health insurance from fragmented sources. It would be desirable to have a single service point where they could request information and clarifications.
- iii) Information on sickness funds' performance is scanty. While the general principles of the LAMal seem to be recognised, people need cost and quality information to assess the advantages of choosing one insurer over others. Compiling ratings of insurers' performance may be difficult and costly, nonetheless information on insurers' basic insurance premiums could be made available in a more easily comparable way. The existence of three different premium-regions in each Canton might be confusing for individuals. Consideration could be given to the possible gains of abolishing such regional differentiation. Moreover, comparisons of premium levels would be facilitated if premiums were reported as absolute values and not only as reduction on ordinary basic health insurance premiums. Finally, there is little comparative information on complementary insurance, so that individuals might find it hard to assess in full the financial consequences that their choice of LAMal-insurer has on complementary insurance covers.
- iv) Currently only some patients' and consumers' associations provide information on sickness funds performance. While their role is an extremely important one, it would be useful to consider complementing this information with other assessments.
- v) Good information should also exist on the availability of different basic health insurance products. While only few people switch, they exercise choice of basic health insurance product to a great degree. People need to understand the financial opportunities as well as possible drawbacks of choosing insurance types other than ordinary basic health insurance.
- vi) Transparency about eligibility criteria for means-tested subsidies for low-income individuals could be increased in each Canton.

80. The balance between the costs and benefits of additional information should of course be considered. While providing more information has a cost, primarily for sickness funds but also for the Swiss authorities, better information disclosure might reduce individuals' switching costs, for example:

- Reducing the costs of gathering and searching for comprehensive and reliable information.
- Reducing the time necessary to make an informed decision.
- Diminishing the costs linked to judgement errors that might lead individuals to reverse their decisions.
- Building individual trust towards the good functioning of the choice mechanism.

B) Incentives to cream skim and risk adjust.

81. Cream skimming and risk adjusting obstruct switching. Insurers currently face incentives to cream skim and risk adjust, which could be mitigated by:

- i) Monitoring insurers' practices in order to detect situations where insurers impede switching, and possibly introducing penalties for such behaviour.
- ii) Reforming the risk compensation mechanism in order to eliminate advantages for insurers deriving from risk selection. The risk compensation mechanism should be continued after 2006 rather than terminated as the legislation intended at first. Some design principles of a more effective system are also presented in synthesis in annex 2.

C) Interaction between LAMal coverage and complementary health insurance

82. While only 20% of the Swiss residents have complementary health insurance, it is difficult for these individuals to separate the two insurance covers. According to the OFAS's survey, only 7% of them keep complementary health insurance at an insurer different from the sickness fund providing basic cover. Individuals with both covers at the same fund often receive one unique contract where basic and complementary insurance are not clearly distinguished⁸⁵. While the Law now expressly forbids linking complementary insurance contracts to basic insurance, some further measures to facilitate the separation of the two insurance covers could be considered, for example:

- Separation at providers' level:
 - i) Requiring providers to present individuals with separate bills for basic and complementary insurance. Individuals would submit their reimbursement claims to different insurers. This could be the case of ambulatory services, doctors' fees, and hospital bills for hospitals applying the system "tiers garant", whereby bills are retrospectively reimbursed by insurers to the individual.
 - ii) Requiring providers to send separate bills to the insurers providing basic and complementary covers. This could be the case of hospital bills for those applying the system "tiers payant", whereby bills are directly settled by insurers. In both case i) and ii), providers' might need to strengthen their administrative systems to ensure separate accounting of basic and complementary insurance covers. One difficulty might derive from the hospital practice to apply cross-subsidisation between basic and complementary insurance⁸⁶. Hospitals might not currently have the accounting and information systems for keeping the two insurance covers independent.

85. OFAS (2000c).

86. OFAS (2000c), p. 11-14.

- Separation at insurers' level.

iii) Requiring sickness funds to settle providers' bills among themselves. Separation would occur at the sickness fund where an individual keeps basic health insurance. The fund would reimburse the entire bill to the individual and then seek reimbursement for services not included in the basic cover from the insurer offering complementary health insurance. This could be the case of sickness funds that out-source the provision of complementary cover to private insurers⁸⁷. Insurers might have to establish accounting procedures for maintaining basic health insurance separate from complementary covers.

Fulfilling the goals of the individual choice mechanism

83. From the analysis presented in this study, some conclusions can be drawn regarding the attainment of the goals originally set for the individual choice mechanism.

A) Enhancing individuals' liberty to choose insurer

84. While the LAMAI has certainly enhanced individual freedom to choose insurer, this goal could be better fulfilled by facilitating the process of choice. Some measures that would reduce the costs of switching for individuals have been recommended above, but other areas where switching costs might exist could be targeted. While facilitating the process of choice might be a costly exercise, individuals will not necessarily switch more as a result. Rather, strengthening the system will enhance the faculty of individuals to choose⁸⁸, a desirable outcome no matter whether they exercise their freedom to switch or not. Clearly, the benefits of enhancing freedom to choose might have to be weighted against the costs of making the choice process easier.

B) Intensifying 'healthy' competition and creating cost-containment incentives for LAMAI-insurers

85. More difficult is to ensure that switching leads to desirable effects on competition and costs. This depends on three factors: a) switching must send adequate demand signals; b) switching should stimulate healthy competition on quality-efficiency ratios; c) the costs of switching for the insurers should be more than compensated by the benefits. From the analysis presented in this paper, some concerns emerge that not all three conditions might be satisfied at present.

86. Demand signals. The sensitivity to sickness fund performance seems currently low, in which case individual choice might not be the best tool to stimulate improvements in sickness funds performance. While evidence indicates that some of the individuals' difficulties in exercising choice can be removed (see measures suggested above), it remains unknown how responsiveness to premium and quality would change with a strengthened choice mechanism. Furthermore, even assuming that switching generates adequate market signals (whether at current or at higher levels) it cannot be concluded that these signals automatically stimulates better sickness fund performance. Improvement in insurers' performance will come only if insurers have incentives to utilise competitive tools to improve quality-price ratios. And

87. According to a study (OFAS, 2000c) and to personal communication with OFAS functionaries, some sickness funds seem to be contracting-out the provision of private health insurance to private providers.

88. For example, strengthening the choice mechanism might induce even more people to change basic health insurance type rather than change insurer.

demand signals will be beneficial for overall cost-containment goals if the additional costs created by the choice mechanism are smaller than savings obtained. Evidence in this regard is not extremely supporting.

87. The quality of competition. Available evidence suggests that competing on risk-selection might be more appealing to insurers than competing on quality-price ratios, and that insurers do risk select in practice. Investments in quality improvements do not seem to be the most appealing strategy for insurers. Insurees are not easily able to gauge quality, therefore it is easier for insurers to spend resources for selective advertising and direct mailing to good risks as this strategy is more effective in attracting lower-cost cases. Moreover, insurers can keep their clients without substantially improving quality or reducing premiums due to the individuals' reluctance to switch. Finally, the current risk equalisation system might not fully preserve the incentives for insurers efficiency that might derive from competition, not only because of the advantages of cream-skimming, but also because compensation is determined retrospectively on the basis of the actual cost of all enrollees. Other forms of risk sharing might provide insurers with better efficiency incentives⁸⁹. While there is no blueprint for a perfect risk equalisation, a wide literature shows how various risk compensation mechanisms can produce different trade-offs between eliminating incentives for risk-selection and maximising incentives for insurers' efficiency⁹⁰.

88. Balance between switching costs and savings from switching. Although the Swiss legislation envisaged enhancing choice-driven competition in basic health insurance in order to stimulate a reduction of sickness funds costs, a preliminary review suggests that no substantial decrease in cost is being achieved through the way the individual choice mechanism is working. On the one side, the system does not create incentives for sickness funds to adopt cost reducing strategies. Currently no sizeable opportunities for containing medical costs exist, mainly because insurers have no room to negotiate a contractual relationship with both individuals and providers within basic health insurance. On the other side administrative costs are likely to increase with switching volumes. Other cost containment measures might be more effective than the current individual choice mechanism in stimulating cost reductions.

89. How to make the switching process lead to 'healthy' competition is a vast topic that cannot be drawn to a close in this report. Nonetheless, some interesting findings have emerged from the analysis. Although individuals' responsiveness to price and quality seems low at present, the measures suggested to strengthen the choice mechanism will work towards improving responsiveness through better information provision and removal of barriers to switch. The quality of insurers' competition can be improved in various ways. A first obvious one is that incentives for cream-skimming implicit in the risk compensation mechanism need to be mitigated, bearing in mind that various compensation formulae yield different trade-offs between incentives for insurers' efficiency and likelihood of eliminating cream skimming incentives. Second, there is perhaps scope for questioning the effects of the ban on profits and the possible implications of lifting such prohibition, since the prohibition on profits do not seem to lead to efficiency improvements⁹¹. Third, this report highlighted how limited are the opportunities for insurers to implement cost-reducing strategies. Ways for making such strategies more appealing or more feasible to implement would certainly help steering insurers conduct towards competition on efficiency levels. For example there seems to be scope for savings through managed care options. Individuals might switch to a sickness fund because of the availability of HMO insurance, and HMO insurance seems to offer opportunities for real

89. Van Barneveld, E. et al. (2001).

90. Van Barneveld et al. (1998); Olivier, A.J. (1999); Van de Ven, W. and Van Vliet, R. (1992).

91. Given the ban on profits, an insurer who can select preferred risks has three possibilities. It can reduce premiums reflecting lower medical costs, which might threaten the existence on the market of another insurer with a worse risk structure regardless of their respective efficiency. It can keep premiums and invest savings in higher salaries and administrative costs, which lowers efficiency. And it can invest in quality improvements, which does not however seem an appealing conduct at present. On the whole, these insurers' behaviours might lead to adverse efficiency effects.

cost savings. If this were the case, incentives would need to be improved so that HMO insurance becomes a more appealing solution both for individuals and sickness funds.

90. In summary it would be desirable to strengthen the individual choice mechanism in order to facilitate liberty of choice for individuals, and some measures have been recommended above. However, measures to improve the switching mechanism should be accompanied by other interventions to foster competition on quality and cost rather than on risk selection. Promoting an increase in the absolute rates of switching might otherwise come at increased costs, without relative benefits or cost savings.

Further analysis is needed

91. To conclude, further analysis might be desirable on the following:

- i) *The sensitivity of individuals to comparative premium and quality levels.* Quantitative estimation could supplement available qualitative analyses on the determinants of choice, individuals sensitivity to variations in sickness funds performance, and changes in sensitivity resulting from availability of better information on sickness funds performance.
- ii) *The determinants of concentration in the health insurance market.* Greater analysis on the causes of market concentration would shed light on why many insurers have exited the market in recent years, and help verifying: a) what competitive tools sickness funds use to improve benefit-cost ratios or select preferred risks; b) whether efficient insurers are being driven out of the market by insurers who can effectively cream-skim; c) whether the health insurance market is moving (or not) towards a theoretical optimal market concentration level, where the size and number of financing pools enable contestability without excessive fragmentation of the financing pool.
- iii) *HMO-insurance.* More analysis is needed to quantify the extent of cost savings that could derive from HMO-insurance. Research into the set of incentives that sickness funds face when promoting HMO-insurance is also needed. This includes for example an analysis of the spread between premiums received by insurers, the compensation paid to the risk equalisation mechanism, and the costs of implementing cost-control measures. More information on the various cost-control techniques implemented by sickness funds under managed-care options would also be instructive.
- iv) *The optimal level of switching.* Information on the marginal cost of each new switch (e.g., administrative costs) and the marginal benefit of such switch (e.g., gains in insurer's efficiency or improvements in quality) would help calculating the optimal level of switching.

ANNEX 1. CHOICE IN HEALTH SYSTEMS

1 Choice within health systems can be exercised by three main players: individuals, third party payers, and providers. Five main cases can be distinguished:

- Individual choice of third payer.
- Individual choice of provider.
- Third payer choice of individuals.
- Third payer choice of provider.
- Provider choice of individuals.

2. *Individual choice of third payer* occurs in systems where people can select where to buy health cover. This might concern choice of insurer in the case of voluntary health insurance cover. However it can also include choice of insurer in the case of social insurance, either when the purchase of private health insurance is mandated by Law (e.g., Switzerland) or when contribution to a social health insurance scheme is compulsory (e.g. Germany).

3. *Individual choice of provider* occurs when people can select doctors and hospitals where to obtain health services. This happens for example in health systems utilising market allocation models, where money follows patient's choice. Conversely, models of managed competition restrict patient choice over providers. The plan manager is responsible for setting contracts with preferred providers while individuals have limited choice over providers.

4. *Third payers such as insurers can choose individuals* whenever risk selection is allowed, that is to say whenever insurers can refuse bad risks and make reservations on their cover. This is often the case in voluntary health insurance, while risk selection is prohibited or at least regulated in the case of mandated insurance cover.

5. There are various cases of *third payers' choice of provider*. In countries implementing internal markets, such as the UK, the purchaser of services, for example a health authority, allocates resources through contracts to competing providers in exchange for types and volumes of health services. Similarly insurers are usually allowed to negotiate conditions and tariffs with providers of their choice (e.g., USA).

6. The last case, *provider choice of individuals*, occurs when hospitals or other providers of medical services can refuse treatment to uninsured individuals. For example private hospitals in the US can reject a patient if s/he is not insured, unless in cases of emergency treatments.

ANNEX 2. DESIGN PRINCIPLES OF AN EFFECTIVE RISK COMPENSATION MECHANISM

1. In health systems with competing health insurers and community-rated premiums insurers face incentives to cream-skim. Compensation mechanisms either among insurers or between insurers and the government/regulator should be maintained if solidarity is to be preserved.

2. Various risk compensation mechanisms can be adopted. Compensations can be centrally determined on the basis of a capitation formula adjusted by predictors of individual health care expenditures. This is the case of Switzerland. Under a second system, sickness funds can be left to determine at the start of the period a fraction of their insurees whose costs will be pooled. Pooling might apply only to a percentage of these insurees' costs, or to the totality. Another method consists in compensating all sickness funds for insurees' costs above a certain threshold. Finally, risk compensation can consist of risk-sharing arrangements between insurers and a central fund, where sickness funds do not bear the risks of financial deficits nor benefit from financial surpluses. Each of these mechanisms creates different incentives for cream skinning, efficiency, and cost containment⁹². The choice of the compensation arrangement will depend upon the relative importance attributed to these policy objectives.

3. A good compensation mechanisms should not adjust for the degree of insurer efficiency, otherwise insurers will see their efforts to be efficient penalised. Mechanisms based on retrospective compensation of differences across insurers' health expenditures might prevent insurers from seeking efficiency gains. On the other hand, prospective compensation formulae might unjustly make insurers responsible for cost differences that are not within their control capacity. A balance between prospective and retrospective compensation should be considered.

4. A risk compensation mechanism is effective if it makes the insurers' marginal cost of risk selecting higher than the marginal benefit. The mechanism should hence calculate compensation on the basis of enough risk-adjusters to make it costly for insurers to predict the likelihood of individual health expenditures better than the compensation formula can do. If insurers can easily derive a more accurate prediction, they will also be able to identify costly cases and cream skim against them⁹³. Risk-adjusters can include socio-demographic factors (e.g., age, sex, income, region); prior utilisation and diagnostic information (e.g., diagnostic-related groups); disability and functional health status (e.g., severe disability measured by Activity of Daily Living or Instrumental Activities of Daily Living); indicators of chronic medical conditions (e.g., indicators on conditions more frequently associated with high consumer of medical services). The first group of risk-adjuster, though easy to apply, does not have as high a predictive power as the other sets of indicators.⁹⁴

5. The risk compensation mechanism should not incorporate too many risk factors. This might make insurers believe that their efficiency gains will be used to cross-subsidise inefficient insurers⁹⁵. Modelling techniques could help determining the point beyond which adding an extra risk factor does not improve the explicatory capacity of the risk compensation formula at the margin. Consideration should also be given to practical concerns, particularly the possible resistance and counterproductive behaviour of sickness funds managers should the compensation mechanisms be perceived to discourage their efficiency efforts.

92. Van Barneveld et al. (1998); Olivier, A.J. (1999); Van de Ven, W. and Van Vliet, R. (1992).

93. Olivier, A.J., *ibid*.

94. Van de Ven, W. and Van Vliet, R. (1992).

95. Olivier, A.J., *ibid*.

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