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Universal Coverage and Individual Mandate in Switzerland: Lessons for Massachusetts

In collaboration with



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Executive Summary

Massachusetts is not the first to mandate that everyone buy insurance as a way to achieve universal health coverage, and is not the first to get queasy about seeing that solution through. Like Americans, the Swiss were not eager to accept the double principles of universal coverage and a mandate on individuals: it took almost a century before these two elements were added to the Swiss system in 1996. Eleven years after, this issue brief presents the challenges Switzerland is facing and the lessons Massachusetts may learn from its experience.

Commonalities:

Switzerland, the United States, and Massachusetts:

1. Have a system that relies on competition among private insurers within a regulated system.
2. Have a system which is built on a mixture of private and public delivery.
3. Consider individual mandate as an effective way to achieve universal coverage.

Lessons:

What have we learned in Switzerland from our decade long experience with an individual mandate that is instructive for Massachusetts may be summarized in four main points:

First, the queasiness felt in Massachusetts is natural, but not a reason to waver. Despite the fact 97 percent of the population already had insurance in Switzerland, the introduction of the individual mandate induced deep modifications in the Swiss culture. Eleven years after the implementation of the individual mandate nobody seeks to be relieved of this obligation.

Second, there is growing scrutiny of insurance companies and heightened demands for accountability in a system in which everyone must purchase coverage. Specific concerns about insurers have focused on the opacity of their business practices and finances, the lack of competition among insurers, and their illegal attempts to identify and enroll healthy people and avoid people in poorer health.

Third, affordability of health insurance has become a huge public issue. With rising health care costs, more than one-third of Swiss families now qualify for public subsidies. Even though federal spending for subsidies for health insurance has more than doubled since 1996, an increasing number of middle-class families cannot afford their premiums.

Finally, the mandate and the reform helped focus attention on the problem of health care costs and sharpened attention to the relative responsibility of major players.

Perhaps the diverse, broad-based coalition of stakeholders that supported health reform in Massachusetts can develop some lessons to share with the Swiss in the areas of affordability and

health care cost control. The Swiss experience suggests that these issues will certainly be your next policy challenges, and critical to the ultimate success of your health reform law.

I. Introduction

Why is the Swiss experience relevant?

Universal coverage has been largely abandoned since the early 1990s by the White House and Congress. However, it is now actively back on the table. The signature of the Massachusetts health care reform bill (April 12, 2006) proves that ideology may be transcended and significant progress achieved. This state is the first in the United States to pass a reform law which includes an individual mandate as a central feature. Thus, at the national level, many lawmakers are now looking to its roadmap as a political and structural model for the nation's 46 million uninsured, as are such states as Vermont, Illinois, Connecticut, and California.

Switzerland is the only developed country with a long-standing universal health care system (eleven years) based on an individual mandate. The Netherlands introduced a comparable system two years ago. The Swiss experience may be a source of lessons for Massachusetts as it implements its own health reform.

Why is a comparison with Switzerland applicable?

Many studies have compared the American health care system to other countries. However, although these countries may achieve better health outcome with lower costs, it appeared impossible to apply their experience broadly to the United States. The

American system and culture are too unique to have lessons applied. As stated by Blendon and Kin, "Canada, Great Britain, and Germany have very different health systems, but they all involve a central role for government in management and regulation, and a willingness to have government redistribute resources and taxes to those who are more successful in order to achieve equity in health care. As a result, Americans learn little from foreign experiences in health policies."¹ The Swiss have a similar reluctance to let the government manage their health system: 69 percent of voters prefer the market to State regulation.² The United States and Switzerland are both federal and therefore decentralized systems, with significant state/canton independence. This shared libertarian mentality may be an explanation for the length of time it took both countries to seriously consider universal coverage. As mentioned by Hsiao, "Compulsory health insurance to cover all Americans remains elusive after more than sixty years of public debate."³ Switzerland was even less in a hurry: it took a century to accept this principle.

Cultural similarities

Americans and Swiss have high expectations for medicine and strong preferences for spending more nationally on health care. These common values may partially explain their respective high rate of health care expenditures per capita (Exhibit 1). The United States spends more of its gross domestic product (GDP), 15.3 percent, than any nation, but it is immediately followed by Switzerland with 11.6 percent (2004).⁴

As stated by Peter Zweifel, one of the four fathers of the law which

implemented universal coverage in Switzerland, “consumer preferences regarding health care are respected to a degree found only in the United States.”⁵ As reported by Blendon et al.,⁶ Americans attribute the rising health care costs to the profits made by drug and insurance companies whereas the Swiss accuse mainly the latter, the costly bureaucratization of the insurers and drug companies – 87 percent consider drug prices as being too high.⁷

As a natural consequence, cultural similarities between the United States and Switzerland may explain common points in financing and organizing their respective systems.

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1. Have a system that relies on competition among private insurers within a regulated system.
2. Have a system which is built on a mixture of private and public delivery.
3. Consider individual mandate as an effective way to achieve universal coverage.

II. Introduction of universal coverage and individual mandate in Switzerland: An overview

Profile

Switzerland is a country of 7.4 million inhabitants covering a territory of 41,285 km². It is a federal state, made up of 26 cantons which vary considerably with respect to their size (on average 40 km²), demography, and socio-economic situation. The native language of about 63.7 percent of the population is German, 20.4 percent is French and 6.5 percent is Italian. A small fraction of the

population speaks Romansch (0.5 percent) and 9 percent speak another foreign language due to immigration (e.g., Serbian, Albanian, Portuguese).

Health expenditures

Switzerland is one of the richest OECD countries. Measured by GDP per capita, it ranks fifth after Luxembourg, Norway, the United States, and Ireland.⁸ Health expenditures as a share of GDP have been increasing steadily over time, rising by 2.4 percent between 1990 and 2003, above the OECD average increase of 1.5 percent. This ranks Switzerland in the second highest position among all OECD countries behind the United States, with total health expenditures of \$42,351 billion in 2004.⁹

Health status

Swiss people generally perceive their health status as good. Around 86 percent of the population claims to be in good or very good health compared with an OECD average of 68 percent. The overall age-standardized mortality rate in Switzerland is estimated at 550 deaths per 100,000 people, making it the fourth lowest OECD country after Japan, Australia, and Iceland. Their life-expectancy at birth is 83 for women and 78 for men.

Political and institutional framework

In Switzerland, power is highly decentralized. There are three primary levels of government which interact regularly. The Confederation is led by a federal council of seven ministers elected by parliament, 26 cantons which each have their own government, parliament and socio-economic profile and communes (2,763 in 2005). As a consequence, the cantons are responsible for organizing and managing the supply

of health care.¹⁰ The large decentralization of political power and the importance of local autonomy in the organization of health care have resulted in a different health system in each of the 26 cantons.

1911-1996: Historical background before the Swiss mandate

The 1911 Federal Law on Sickness and Accident Insurance (LAMA), inspired by a Bismarckian model of social insurance, covered health insurance in Switzerland until it was replaced by the LAMal (Loi Fédérale sur l'Assurance Maladie) in 1996 (voted December 1994). Before that, insurance was not mandatory. The same insurer could offer both public and private insurance. The majority of people chose to get a basic public insurance which was subsidized through tax revenue. There were huge variations in premiums between insurers and important difference between benefit packages offered. As a result, it was extremely complex for a patient to determine which insurance to choose.

The Swiss were ready to accept a major change in their system because of high and rising health care costs (costs had doubled between 1985 and 1995 and were estimated at \$29 billion),¹¹ and the need for improvements in quality and access to care. Federal regulations were loose in the private insurance market. For example, private insurers could refuse patients if they were suffering from illnesses or if they considered a potential client too old. Most imposed a surcharge (i.e., a higher premium) on sick people during at least five years. As a result, the responsibilities of the federal government became greater, as people

who could not afford coverage had to be taken care of by social welfare.

As in the United States, employers were involved in the health system. Large public and private enterprises helped pay a portion of employee health insurance premiums. In 1995, approximately 1.6 million people were insured through an employer-based system (22 percent).¹² However, during the 1980s, the economic crisis pushed some employers into bankruptcy, and employees had to find another insurer who might then impose surcharge on them according to their age or health status. As reported by former Minister of Internal Affairs Ruth Dreifuss, “this organization made patients very vulnerable, and convinced many of them of the need for a legislative change which promised to protect them against economic circumstances by offering coverage independent from the employer.”¹³

Despite the challenges in the voluntary Swiss system, almost all the Swiss had health insurance coverage – 97 percent in 1995. This exceptionally high rate may be explained culturally. Being insured is historically deeply rooted in the Swiss tradition. “Getting insurance on the future” means trying to ward off a feeling of fragility in a country totally dependent on the exterior.¹⁴ Besides, 16 out of 26 cantons, including Geneva, had already implemented individual mandates prior to 1996.

Finally, premiums were quite affordable. The minimum monthly premium was \$70 and people could choose between different deductibles to lower their premiums. Almost 80 percent of the insured population chose the lowest deductible, \$123.¹⁵

Like the United States, Switzerland has a history of failed attempts at national health care reform. Since 1911, there were four failed attempts to reform the system (1920, 1947, 1972, and 1986). Political antagonisms always prevented Switzerland from implementing any of the changes.

Partisan cleavage transcended

Thanks to a slim majority (51.8 percent), a new law survived a referendum on December 4, 1994. The LAMal, inspired by the managed competition theory, aimed to achieve three main objectives: making health care costs equal across age and gender (the law forbids surcharges based on gender or age), containing health expenditures, and guaranteeing equity through a high-quality basic health service.¹⁶

The major innovation was the change from a voluntary to a mandatory health insurance system in which insurers had to provide the same benefits to all. People who wanted to get additional benefits (e.g., a private room in a hospital) could do so through the purchase of additional supplemental coverage.

1996-2007: The main characteristics of the Swiss individual mandate

Unlike Massachusetts, where the mandate applies to people only if coverage is affordable, the Swiss individual mandate applies to everyone. The most disadvantaged are helped through federal subsidies.

Premiums

Individuals have to take up insurance within their canton of residence; they are free to choose among a range of sickness funds (87 in 2007). Insurers are obliged to accept any resident, without discrimination, even illegal immigrants.¹⁷ Premiums are not income-related. Low-income and wealthy individuals pay the same amount for the same coverage from the same sickness fund in the same canton. Switzerland has community-risk pooling. Insurers calculate their premiums differently in each canton. Premiums are defined according to the spending of each insurer, the level of their reserve, and the supply density of providers in each canton where they are established. Every insurer has to reimburse the same benefit package of services (even though some have made a national pastime of freely interpreting the law). As a result, the Swiss are facing a range of prices, rising premiums, and greater inequalities between cantons.

Every insurer can offer different types of plans: free access to every provider, gate-keeper, bonus insurance (the premium diminishes proportionally to the number of years during which the patient claimed no reimbursement) and various models of managed care. Finally, insurers fix three age-related categories of premiums: children (0-18), young people (19-25), and adults. The Federal Office of Public Health checks the new premiums each year: up to 100,000 different types last year. This ironically makes control almost impossible and is currently a topic of intense debate.¹⁸

Subsidies

The Confederation participates through taxes, and so do the cantons, which are

also responsible for defining the criteria for assistance. Decentralization leads to significant disparities between cantons. For example, in 2004, Soleure subsidized 23 percent of its population (lowest) whereas Obwald helped 54.1 percent of its inhabitants (highest).¹⁹

Affordability

When the law was implemented, authorities defined the upper limit of share for out-of-pocket payment (i.e., the total percent of income that should be contributed to health insurance) at 8 percent of the taxable income. But even if it was the official political ambition, this was not included in the statute and thus had no force of law.

Enforcement and penalties

Cantons are given the responsibility for making sure every resident receives coverage. Not obeying the individual mandate is ultimately enforced through law suits. As an example, Geneva expects every newcomer to the canton to get insurance from the sickness fund of his choice within three months. In case of a refusal by the newcomer, the canton assigns the latter to a sickness fund (usually the cheapest) in an authoritarian way. The newcomer is billed by the sickness fund and liable for payment of his premium and if he fails to do so, he will be in debt to the insurance he has been assigned to.

A comprehensive benefit package

A comprehensive package of health care coverage is specified by law. Services are far more generous than other European countries.²⁰ Switzerland has what is called an “implicit catalog” which includes reimbursement for most every treatment ordered or provided by a physician. Dental care is excluded unless

related to a systemic illness. As former Health Minister Ruth Dreifuss comments, “It relies on a confidence-contract with physicians as they are the ones who evaluate the necessity of a treatment.”²¹ Risks covered include illness, maternity, and accident (if not provided through employer). The basic insurance reimburses treatment and stays in public wards of a hospital approved by the canton. Stays in semi-private or private sections are paid out-of-pocket or by private insurance. There is an explicit list of covered prescription medication.

Cost-sharing

Individuals share in the cost of health service through deductibles, co-insurance, and co-payments. The co-payment of 10 percent (maximum of \$574), combined with an annual \$246 deductible (minimal co-payment), results in a maximum amount of cost-sharing to be borne by an individual covered by an ordinary insurance policy of \$820. To lower premiums, the insured may choose among a list of possible annual deductibles from a mandated minimum of \$246 (franchise de base – for an adult over 26 years) to \$2,050. The federal government regulates the maximum discount off the standard premium and it sets the maximum reduction in premium that can be given to someone who chooses the \$2,050 deductible.²²

According to the new revision of the LAMal approved in spring 2005, cantons will also be required to reduce (through subsidies), by at least 50 percent, the insurance premiums for children and young people in further education and training, living in families with low or middle incomes.²³

Financing

The Government's major aim back in 1994 was to limit its costs for health coverage, but this has not been the case. Funds are spent on subsidies to institutional providers (e.g., hospitals, long-term care institutions, home care), as well as prevention, public health and administrative charges. Out-of-pocket spending by consumers, at 32 percent is almost double the United States, and is the fourth-highest percentage of overall out-of-pocket health expenditures in the OECD area.²⁴ Finally, 10 percent of total health expenditures are channeled through voluntary supplemental private health insurance, one of the most significant shares of total spending in the OECD area after the United States, the Netherlands, France, and Canada.²⁵ In 2004, public contributions (confederation and cantons) were \$9 billion.²⁶

Twelve years of universal coverage and individual mandate

Major attempts at improvement by providers

Physicians

Over the years it appeared obvious that the fee-for-service payment system would be an incentive to encourage the growth of supply. With a ratio of 3.6 doctors, 10.7 nurses, 0.5 dentists and 0.5 pharmacists per 1,000 people, Switzerland has a supply of health workers greater than most OECD countries.²⁷ The law authorizes full freedom of choice of physicians and unlimited access to general practitioners and specialists. The LAMal established that a provider's bill should be based on fees agreed on by insurers and providers, or fixed by authorities. In order to better

control fee-setting, in 2004, a new system of price setting was enforced by the Federal association of Swiss physicians (FMH). Called TARMED, it made it possible to bill ambulatory services on the same basis all over the country, giving points per service. For LAMal covered services, insurers are required to reimburse services delivered by all providers authorized to practice within the context of the LAMal. Rising concerns about oversupply of doctors has led to the introduction of a policy which limits the number of students accepted each year at the universities. In addition, the right to open a new medical practice has been frozen since 2002 and will be until at least 2008.

Pharmacists and pharmaceuticals

The Swiss population spends USD \$398 per capita on pharmaceuticals, above the OECD average of USD \$380 per capita but only half of the per capita expenditures in the United States.²⁸ In order to limit consumption, since April 1, 2006 people who persist in wanting the brand-name drug have a co-payment of 20 percent instead of 10 percent. As a result, the market share for generics has increased to 42 percent. Considering the first nine months of 2006 compared to the same period in 2005, increase in drug expenditures appeared to be stabilized (+0.3 percent).²⁹

Providers in hospitals

Switzerland has 134 private hospitals and 220 public hospitals, which means 3.9 beds for 1,000 inhabitants, compared to 2.5 in Massachusetts.³⁰ As length of stay begins to be a political preoccupation, and as hospital expenditures are still increasing by 4.4 percent per year, serious discussions have begun about introducing diagnosis-

related group (DRG) payment instead of per diem.

Insurers

Because insurers must enroll all applicants, some may end up with a larger pool of people at risk for higher health care costs than others. As part of the original law, the legislature has implemented a post-enrollment risk adjustment scheme based on age and gender. It is now considering adjustments that would add new criteria to risk adjustment (e.g., number of days of hospitalization during previous year).³¹

Swiss law prohibits insurers from engaging in any form of risk selection but some insurers have developed strategies to circumvent this rule. Parliament regularly discusses ways to prohibit good risk hunting, but so far no effective solution has been found.

III. Three major challenges

1. Maintaining an endangered universal coverage

After eleven years, “does our system still deserve to be characterized as one with universal coverage?” asks Gianfranco Domenighetti, former head of the Public Health department of the Ticino.³² Swiss Health Monitor reports that half of the population encounters regular or occasional difficulties paying their premiums.³³ In its message in November 1991, the Federal Council defined 8 percent of taxed income as an acceptable threshold for out-of-pocket payments. According to Balthasar et al., this threshold corresponds to 6 percent of the available after tax income.³⁴ In 2004, 18 of the 26 cantons failed to provide

subsidies sufficient to meet the 8 percent of taxable income cap.

Containing the cost of subsidies

As a consequence of rising premiums, the proportion of the population who needs help to afford these premiums has increased dramatically throughout the years, raising the amount of subsidies from \$1,224 billion in 1996 to \$2,599 billion in 2005.³⁵ A third of the population now fulfills the criteria for public subsidies for compulsory insurance and this proportion will increase further.

2. Controlling costs

In 1996, the new law aimed at solidarity but 12 years later, Switzerland appears to be unable to afford the price of this noble ambition.³⁶ Healthcare costs increased from \$12.9 billion in 1997 to 20.4 billion in 2005.³⁷ As reported by OECD, spending on health as a share of GDP (or GNP) is among the highest in the OECD area, and continues to increase more rapidly than GDP. Authors underline that other OECD countries perform equally well, or even better, at lower levels of health spending.³⁸

Controlling demand

One explanation for the lack of success at controlling health care costs is the law itself, which provided no incentive to limit consumption (e.g., by making an HMO or managed care mandatory). As mentioned by Peytremann Bridevaux and Santos-Eggimann, “the almost unrestricted access to health care allows patients to seek physicians who respond to their expectations.”³⁹ Domenighetti and Pipitone estimated that patient-induced demand resulted in 34 percent

additional medical requests from patients.^{40, 41}

Defining incentives to limit supply

Swiss culture and the country's strong concerns about the protection of privacy, added to a liberal mentality (in the European definition) among providers, have made any implementation of technology assessment/cost-effectiveness analysis very difficult.

Accelerating DRG

The predominant payment mechanism for hospitals is per diem or bed days. However, since the introduction of the LAMal, there has been a trend towards new remuneration mechanisms based on services, such as DRGs (primarily using the all-patients diagnosis-related group classification) but the process remains slow because of strong resistance from cantons.⁴²

Finding a balance between prevention and cure

In Switzerland, 2.2 percent of health expenditures (\$0.82 billion) are devoted to disease prevention and health promotion compared with an average of 2.7 percent for all OECD countries.⁴³

3. Introducing real competition into the insurance market

Throughout the 20th century, the number of insurers has regularly decreased from 1,151 in 1945 to 87 today. This may lead one to think the Swiss insurers' market is characterized by stronger competition. However, this is not the case. Among these 87, eight share 79 percent of the market.

As a consequence, one of the great expectations about the law in 1996 has not been satisfied, and few people have

moved from one insurer to another. Rather, what emerges is that the majority of insured persons stick with their insurance company even if premiums are 50 percent higher than the least expensive offer.⁴⁴

Defining incentives through insurance plans

As underlined by Peytremann Bridevaux and Santos-Eggimann, "for the one third of Swiss residents who receive health insurance subsidies, there is no incentive to choose contracts that include high deductibles, health maintenance organization, or bonus plans."⁴⁵

4. Any lessons for Massachusetts?

Individual mandate and universal coverage can be accepted by a reluctant population

Even if pockets of resistance were strong before the introduction of the individual mandate in Switzerland, eleven years later, nobody tries to be relieved of this obligation. Enforcement has been helped of course by the high level of insured people but also by the fact that people who were resisting were not strictly penalized. They were forced to get insurance, but the amount of their penalty bought them the coverage. This is unlike Massachusetts, which will exempt people from the mandate or penalize them for failing to comply with it, but leave them uninsured.

Individual mandate increased awareness

Changing to a mandatory system did increase awareness among the main actors of their respective responsibilities. In a decentralized country, an individual mandate may encourage the

development of innovative solutions to access, cost and quality problems.

Suppressing the employer-based insurance system may induce more equity and stability in the system

By renouncing the employer's involvement in the health system (22 percent of the population before the mandate), Switzerland has broadened the risk pooling. Suppressing the involvement of the employer can minimize risk pooling by type of activity. Community pooling is more equitable and more stable.

The individual mandate has increased the demand for accountability for insurers

Insurers can expect greater scrutiny and demand for accountability in a system in which everyone must purchase coverage. They will be less able to risk-select healthy people and avoid people with potentially high health care costs. Further insurers will have to be more open about their business, collection, and finance practices. As an example, at the beginning of March 2007, popular anger in Switzerland was so strong that insurers were obliged to soften a recent measure they had just introduced to punish people who cannot afford their premiums.

Cost control is impossible if responsibilities are fragmented

The Swiss health care system is highly decentralized. This lack of centralization and the historical respect of canton autonomy have rendered the health care system vulnerable, making any attempt to improve it difficult if not impossible. Besides, as in the United States where each state manages unique Medicaid programs, cantons have developed their

respective interpretation of the aim of solidarity contained in the law.

The high deductible effect is an illusion

Lower consumption among clients with high-deductibles appears to be due to adverse selection. Mortality rate among people enrolled in low deductible plans was considerably higher than those enrolled in high deductible plans. In a study considering samples of 25,314 insured people, the mortality range of plans with a \$189 deductible was 2.07 whereas it was just 0.69 among deductibles of \$600 or more.⁴⁶ Besides, opacity of the system and increasing burden of premiums on the household could push some of them to increase consumption once the limit of the deductible is reached and to multiply visits to their physicians before the next year's deductible takes effect.⁴⁷ As stated by Claude Longchamp, author of the main Swiss health surveys, "High premiums feed high expectations."⁴⁸

Universal coverage coupled with subsidies may catch middle-class in a vise

The threshold effect imposed by the subsidy system has driven households who are just above the limit to face increasing difficulty in meeting their premiums. Switzerland is seriously considering the idea of adapting the premium to family income. "Adapting premiums to income has been fought by the right for 15 years, but the rapidly rising number of subsidies, and difficulties in increasing new taxes are making that possibility more attractive" states Alberto Holly, Professor of Health Econometry at the University of Lausanne.⁴⁹

Competition has to be “unmanacled”

Switzerland has encountered certain pitfalls with a competition system comparable to the German one, described by Lawrence D. Brown and Volker E. Amelung as strongly “manacled.”⁵⁰ In reforming systems containing both universal coverage and individual mandate competition, as in Massachusetts, could be improved by considering the following points:

1. Any system looking for efficiency should forbid its insurers from managing simultaneously basic insurance and private insurance; insurers should be obliged to establish two separate sets of accounts and should be forced to demonstrate transparency.
 2. “Risk adjustment should be based not only on sex and age but also on the health status of the insured people” as suggested by Alberto Holly.⁵¹ He also proposes that in order to transform the risk adjustment into an incentive, it should be prospective and not retrospective.
 3. Finally, he suggests provision should follow the individual. Today, if somebody quits a sickness fund his provision stays there. This means the fund becomes richer whereas the new one – although it should be rewarded for its attractiveness - is impoverished by the new entrants, setting the basis for an inflationist system.
 4. If different plans are proposed incentives should be stronger.
- Switzerland is finally discussing the possibility of introducing opportunities for increasing co-payment from 10 percent to 20 percent for those who refuse the gatekeeper system and for increasing the range of deductibles over \$2,050, even though this might contain

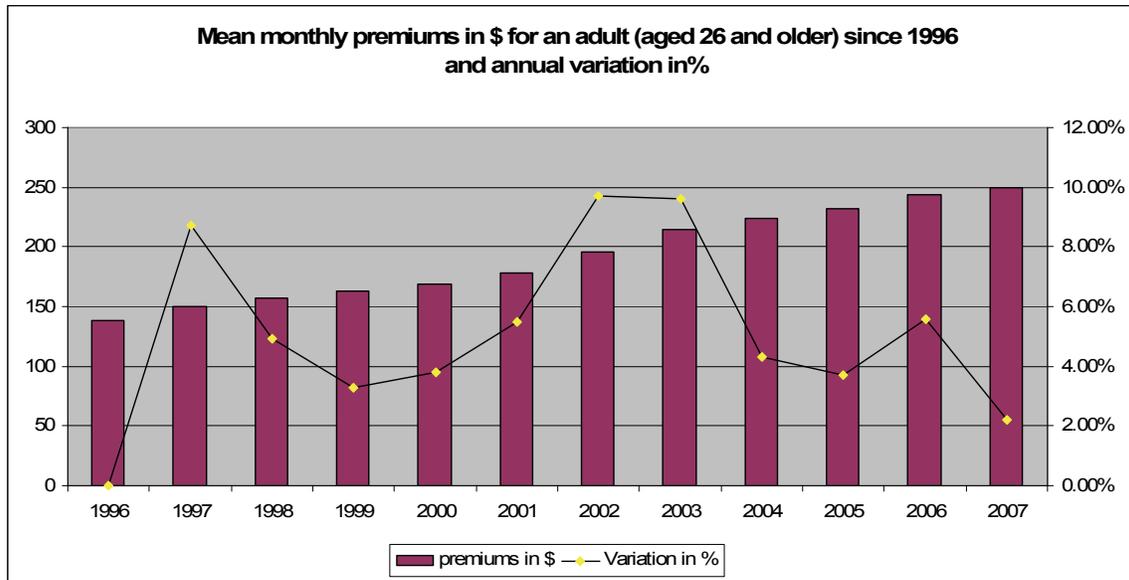
the risk of damaging the main objective of the Swiss Health system: solidarity.⁵²

5. Conclusion

An eye on the future

Eleven years after universal coverage and a mandate on individuals to purchase health insurance were introduced, 72 percent of Swiss voters recently rejected a proposal to replace the current 87 private insurance companies with a single health insurer financed by income-related premiums. Although this vote demonstrated that the Swiss prefer incremental change, it was far from an all-out endorsement of the current system. The Parliament is now debating a number of new modifications to the law from all sides. Members on the right are seeking to suppress an “any willing provider” clause which would require insurers to pay for care received from any provider of the patient’s choice. On the left, socialists continue to advocate for premiums based on income and ability to pay.

Costs remain a concern for all, as the Swiss government addresses the growing expense of providing public subsidies to those who need help paying for health insurance, and many of those ineligible for subsidy struggle to meet the individual mandate requirement that they purchase coverage.



Source: Statistics for sickness insurance, Federal Office of Public Health

Nevertheless, the latest figures published by the Swiss government indicate a slight hope. Although these figures have to be considered with caution, the rate of increase in costs, while still high, diminished between 2003 and 2004 (from 4 percent to 3.5 percent). Increases in premiums have never been as low as for 2007 (2.2 percent compared to 5.6 percent in 2006).⁵³

Switzerland has led the way for Massachusetts on the adoption of a mandate on individuals to purchase health insurance. Perhaps the diverse, broad-based coalition of stakeholders that supported health reform in Massachusetts can develop some lessons to share with the Swiss in the areas of affordability and health care cost control. The Swiss experience suggests that these issues will certainly be your next policy

challenges, and critical to the ultimate success of your health reform law. In any case, on both sides of the Atlantic efforts have been made to do better than the solution proposed by Woody Allen: “The best way to limit health expenditures is to die.”

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