

COST CUTTING IN THE UNITED STATES: HEALTH CARE POLICY

LESSONS FROM SWITZERLAND

A THESIS SUBMITTED TO THE GRADUATE SCHOOL IN PARTIAL  
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE MASTER OF  
ARTS

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MUNCIE, INDIANA

DECEMBER 2012

## **Introduction**

Health care expenditures in the United States are monstrously high and still climbing. The U.S. spends a larger percentage on health care than any other country in the world. In 2009, the World Health Organization reported that the U.S. spent 17.6 percent of its Gross Domestic Product on healthcare.<sup>1</sup> In terms of quality of health care systems, the WHO ranked the United States 37<sup>th</sup> in overall health efficiency, and the same data lists Switzerland 20<sup>th</sup> in the world (Appendix A, pg. 45). It spends 11.4 percent of its GDP on health care expenditures. However, government spending on health care in Switzerland is only 2.7 percent of GDP, which is the lowest in the developed world (Roy, 2011). According to Avik Roy (2011), if the United States could move its health care spending to Swiss levels, it would save more than \$700 billion a year.

Switzerland's legislature approved universal health care reform in 1994. Enactment of the health reform law came just years later, following a referendum vote by the people. Before the reform, Switzerland had a decentralized system with decisions left up to each individual canton; the system resembled a mosaic of 26

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<sup>1</sup> At 17.6% the United States spends more of its Gross Domestic Product on health care than any other developed nations. The next highest spending by a developed nation is Netherlands with 12%.

distinct cantonal health care systems (Reinhardt, 2004). The reformed Swiss law is compulsory and in 2014, the country will celebrate twenty years since its passage. That same year, the United States will institute the individual mandate component of the Patient Protection and Affordable Care Act. As a result of Switzerland's law being nearly twenty years old, there is an abundance of information the United States can learn from a comparison study. During the last twenty years, hospitals and insurance companies in Switzerland have created new methods for saving on health care costs. We can learn lessons from those successful policies.

Health care expenditures are the biggest long-term driver of national debt in the United States. Health care spending is growing at about one and a half times the rate of growth of the GDP; and if the trends of the last twenty years continue, health care spending will consume the U.S. GDP in our children's lifetimes (McClanahan, 2012). Commonly cited problems that are propelling health care costs in the United States are Medicare, Medicaid, and Social Security, or MMS. Obligations to these programs are large and will continue to grow as the 77 million baby boomers enter retirement (Kotlikoff, 2007). In 1965, MMS payments to the elderly were only 28 percent of per capita income, however in 1980 the government doled out MMS benefits equal to 63 percent of per capita income. Additionally, by 1995, the government's generosity had reached a new level, with MMS spending of 79 percent of per capita income. It is projected that this spending will climb to 88 percent of per capita income by 2020 (Kotlikoff, 2007).

However, benefit-spending levels of Medicare and Medicaid are rising much faster than that of Social Security. In the United States, there is no direct control over spending on Medicaid and Medicare. Program participants decide how much healthcare services they'd like and send most of the bills to the government.. Our system is the opposite of those in socialist governments, which have more control over health care spending.

The nation's health care spending troubles create other problems. The issue threatens the nation's ability to pay for new treatments and technologies that are seen as too costly and would qualify as discretionary expenditures. It has also prevented the federal government from achieving universal insurance coverage (Bentley et al, 2008). Almost 47 million Americans are uninsured and almost all of those are working age or younger; that's almost one in five working-age and younger Americans with no health insurance (Kotlikoff, 2007).

Switzerland's health care policy has ensured that everyone in the country is covered by an insurance plan, while still keeping per capita costs below those of the United States. The law is compulsory, meaning everyone is obligated to buy into a health insurance policy once they have been in the country for three months. The basic health plan costs the same amount of money for everyone over the age of 26, regardless of advanced age or health (Rovner, 2008). Policies for children cost less than policies for adults. For those who cannot afford a basic plan, the government subsidizes premiums. According to information from the Swiss Federal Office of Public Health, that basic plan covers things like the cost of procedures and

examinations designated preventative care, including routine health exams, vaccinations, gynecology screening, mammography, and more (Appendix B, pg. 46). No one can be denied coverage for a pre-existing condition. In addition, citizens are able to purchase a supplementary insurance plan in addition to the basic plan. Such a plan covers things like dentistry, acupuncture, homeopathy, infertility treatments, and even private hospital rooms. These types of plans are popular in Switzerland (Rovner, 2008).

The Swiss law has been compared to both the 1993 Clinton health care plan and the 2006 Massachusetts health reforms (Crespo, 2009). The Massachusetts plan created near universal insurance coverage, setting minimum standards for health insurance and mandating that employers offer insurance and individuals must have *it* (McClanahan, 2010). The Clinton health care reform used terms such as alliances, managed competition, mandates and cooperatives, but it was overwrought with operational layering and complexities (Donnelly and Rochefort, 2012). The Obama health reform has been described as a reaction to the Clinton health care debacle. The Clinton plan became a blue print for what not to do in health reform (Donnelly and Rochefort, 2012). However, all three plans drafted in the United States differ from the policy in Switzerland in that the Swiss purchase sickness insurance individually rather than through an employer.

The two countries are similar in that they both have aging patient populations. In the United States, there are 77 million baby boomers that are heading into retirement (Kotlikoff, 2007). That's about 24 percent of the nation's

population that will experience growing health problems and increasing health expenditures. In Switzerland, that percentage is 17, however projections estimate the percentage of individuals 65 years and older will increase to 28 percent in 2050 (Berchtold and Peytremann-Bridvaux, 2011). The aging population in Switzerland is accompanied by an increased life expectancy; in 2004, the life expectancy for women was 83.7 years and for men it was 78.6 (Berchtold and Peytremann-Bridvaux, 2011). However now, the life expectancy is 84 and 80 respectively (World Health Organization), which earns Switzerland a top four ranking for life expectancy among world countries. On the other hand, according to the data from the World Health Organization, the United States does not break into the top thirty on the list for countries and life expectancy. It is ranked just above Cuba with males expected to live 76 years and females 81 years (Appendix C, pg. 48).

Thus, the needs of both countries are changing as the health care industry deals with a new set of problems brought on by an older patient population that is living longer than in decades past.

## **Previous Research**

There is a great deal of research and scholarly articles on health care, however most focus on problems and not solutions. Much of the information helps explain the background of the health care system and reasons behind the spending problem. The topics I look at include Medicare, Medicaid expansions, payment methods, malpractice laws, and wasteful spending. Despite the amount of research previously conducted on these topics, there is a lack of comparative research on cost-cutting methods in other countries.

Medicare's expenditures have continued to grow as the government has extended benefits to cover more and different kinds of health care needs. Medicare offers coverage for parts A, B, C, and D. According to Medicaid.gov, Part A includes hospital and nursing facility care, hospice and home health care. Part B includes ambulance service, mental health care, and getting a second opinion before surgery. Part C allows a person to choose to receive all of health services through a provider organization; this type of plan is said to help lower costs. Part D is voluntary and offers prescription drug coverage (Medicaid.gov). Both parts A and B include extensive cost sharing in the form of deductibles for the beneficiary (Atherly, 2002).

Most Medicare beneficiaries supplement the government benefit package with additional insurance. When a beneficiary purchases a supplemental insurance policy, the policy changes the prices the beneficiary pays for Medicare covered services (Atherly, 2002). In a study on the effect of Medicare supplemental insurance plans on Medicare expenditures, researchers found that there is an association with increased expenditures (Atherly, 2002). Furthermore, the study found in individual and employer-sponsored policies there was significant unobserved favorable selection into plans with and without prescription drug coverage. Favorable selection is the selection of participants based on data that shows a tendency for lower utilization of health services when compared to the rest of the particular population group. In using favorable selection, insurance agencies and medical groups keep costs down without having to deny someone coverage or implement budget cuts. In the study, the individual supplemental plans without prescription drugs increased Medicare expenditures by \$914 annually, while those with drugs increased Medicare expenditures by \$491 while the employer policies increased Medicare expenditures by \$207 for plans without drug coverage and \$447 with the coverage (Atherly, 2002).

Medicare payments are established through a prospective payment system (PPS). Patients are broken down into hundreds of diagnosis related groups (DRG) and the DRGs are assigned a relative weight, based on average costs of treating people in that DRG in previous years (Cutler, 1998). In the late 1980's and early 1990's there were several instances of governmental reform that reduced payments

from Medicare. The reforms saved the government millions of dollars, however that cost savings means hospitals received less money (Cutler, 1998). Cuts in those Medicare payments resulted in cost cutting and cost shifting to patients with private insurers. Under the DRG system, Medicare has administered prices and the hospital has no leverage over the price received from Medicare. However, the hospital is able to negotiate the prices it charges to private insurers (Cutler, 1998). If a hospital can charge more for services, profits will be higher. The DRG system leads to a trend in hospitals favoring those with private insurers over those with government funded plans. It can also lead hospitals to cherry pick the patients they will cover. A hospital may find it needs to raise its privately insured patient population so it can shift costs to cover for Medicare patients. Similarly, hospitals might respond by discouraging poor patients from being admitted to the hospital, leading to reduction in care for the poor.

According to Cutler (1998), cost cutting in hospitals may happen in two ways. First, providers might respond to lower Medicare payments by paying factors of production less. Those factors of production are people like doctors, nurses, and orderlies. Also, hospitals might cut costs by reducing services; they could cut down on services across the board or modify procedures for certain groups of patients. As another concern, Cutler questions whether some hospitals will have to close or reduce their size as a result of Medicare cuts. This is a round about way of reducing services because hospitals are not able to provide those options to as many people.

There is an increasing trend of hospitals contracting with private organizations for health services that were formerly supplied by public agencies (Clark et al, 1994). When it comes to federal funding, the government seems to favor for-profit institutions and agencies over public institutions and agencies. For-profit agencies often look more like profit-maximizing firms as they come to depend on clients for a significant proportion of their revenues. Whereas, public agencies still receive most of their revenues directly from the government rather than through clients (Clark et al, 1994). However, the tendency to behave more like a for-profit business is not necessarily a feature of ownership. According to Clark et al, critics of privatization see pressures to abandon traditional goals of financial access and acceptance of referrals from public hospitals as the inevitable result of increasing competition.

Medicaid is another major spending culprit in the U.S. health care system. Many view the program as fiscally troubling due to the continued expansion of benefits to people with lower incomes. The government has attempted to lessen the health care coverage gap by extending benefits to those who are considered the near poor, or those just above the poverty line. Children have been the subjects of most of the expansions. Medicaid went into effect in 1969 and according to Medicaid.gov, one of the determinants of coverage is the percentage a family's income falls above or below the poverty line. The poverty line is different for families depending on size and it changes yearly based on inflation. For example, in 2012 a family consisting of just one person is living in poverty if income is \$11,170

or less. Where as a family of four must make \$23,050 in order to reach the poverty line (Health and Human Services, 2012). The federal government mandates a minimum of coverage for all states; from there, the states have latitude to extend programs to cover more people. They can do so through expanding poverty limits and/or including coverage for certain groups of handicapped people. Many of the medical services available for children including preventative and medically necessary services are not subject to benefit limitations that are applied to adult Medicaid recipients.

The fact that the states have so much discretion in how far and fast the expansions are implemented provides a rare opportunity to separate the effect of Medicaid from a child's socioeconomic status (Lykens & Jargowsky, 2002). To study the effects of Medicaid expansions on children, Lykens and Jargowsky (2002) explored varying indications of child sickness like the number of days spent in bed due to illness, the number of days absent from school due to illness, and the number of days when a child's normal activities are restricted due to illness. The authors found evidence of varying effects for the different races when it came to expanded health care coverage and children. The study showed white children experienced statistically significant reductions in acute health conditions and functional limitations. On the other hand, black and Hispanic children showed some evidence of improved health conditions, but this evidence is inconclusive in the study sample. This could be due to differences in their access to appropriate health services or to

the smaller sample size of minorities in each geographic area (Lykens & Jargowski, 2002).

Expanded coverage for Medicaid means increased numbers of enrollees. In 2007, 60 million people were enrolled in the program, that's up 34.7 million in only 17 years (Kotlikoff, 2007). The goal is to reduce the poverty gap in the United States. The poverty gap is the amount of additional cash income needed to bring every poor person up to the official poverty line (Weinberg, 1987). However, research shows the amount spend on Medicaid programs is larger than the poverty gap, which according to Weinberg (1987), means that poor families are not the only ones benefiting from Medicare aid programs.

The system of payment that most doctors and hospitals have operated under is fee-for-service. The health care provider bills the insurance or government for the expenses incurred during the treatment. Fee-for-service providers are paid for all services, regardless of whether they are necessary; they are often criticized since they seem to lack any incentives to ration (Bently et al, 2008). Thus, this fee-for-service method of payment is seen as a problem in health care in the United States. In an attempt to control spending, there has been a rise in what's called Alternative Delivery Systems (ADS). ADS is an umbrella term covering a variety of organizational structures such as Health Maintenance Organizations or HMO's, Individual Practice Associations or IPA's, and Preferred Provider Organizations or PPO's (Freund & Allen, 1985).

Although studies have shown that HMO's spend less, the costs in those practices have risen at the same rate as that of fee-for-service (Newhouse et al, 1985). Furthermore, those enrolled in HMO's have experienced approximately the same rate of increase in medical costs as those in the fee-for-service system. According to research by Newhouse et al, HMO's are subjected to a market test that the fee-for-service insurance plans are not. That's because HMO's generally have a less rapid rate of innovation. So, patients must decide whether they want lower costs and lower levels of innovation or higher costs with higher levels of innovation. In the end, it is up to the doctor which payment plan to operate under. There are many considerations that go into such a decision, including income level, satisfaction, size of a doctor's practice, and how long that doctor has been practicing in a certain area (Freund & Allen, 1985).

According to research, the method of health care payment, fee-for-service or otherwise, can affect if a patient will actually go to the doctor. PPOs are designed to change the spending behavior of both beneficiaries and providers. The typical PPO plan is an option incorporated in a standard fee-for-service insurance plan (Wells et al, 1992). Individuals decide whether to use a PPO on a per-service basis, but incentives such as reduced cost sharing or expanded benefits are often used to encourage beneficiaries to use PPO providers (Wells et al, 1992). Research by Wells et al (1992) examined the probability of a change in medical care use in a sample group of employees who enrolled in fee-for-service plans one year before and two years after a PPO option was offered by three employers in two U.S. cities (Wells et

al, 1992). They wanted to explore whether those who indicated they would use a PPO actually used a PPO. The findings showed no significant effects on the intent to use PPO providers on the annual probability of use of outpatient mental health services by the second year after implementation (Wells et al, 1992).

The health care spending problem in the United States can be understood by examining a theory known as The Tragedy of Commons. The theory explains what happens when members of a society contribute to or subtract from a common pool of a resource. The Tragedy comes into play at the point of social stability when there is too much contributed or taken out of the resource pool (Hardin, 1968). This lesson relates to health care and the usage of resources made available by the health care industry. Numerous tests and procedures are made available to patients under insurance plans, so they often consume the tests and procedures because they can. According to Hardin (1968), there is no solution to the problem. As a population rises the so-called tragedy gets worse and each person becomes locked into a system that compels spending increases. One way to break this cycle is for the government to pass a law that requires users to pay for more of the services they are receiving.

Wasteful spending is seen as a reason for some of the fiscal problems facing the health care industry. The undesirable consequences have been broken down into three categories: administrative, operational, and clinical (Bently et al, 2008). By classifying the waste, researchers and scholars are able to better understand the causes of and possible solutions for wasteful spending. Administrative waste is seen

as any administrative spending that exceeds that which is necessary to achieve the overall goals of the organization or the system as a whole. According to Bently et al, much administrative expenditure in the United States is due to its complex, fragmented multiple-payer health care system. Operational Waste refers to the inefficient and unnecessary use of resources in the production and delivery of services; examples of operational waste are the duplication of services and medical errors. Clinical waste is spending to produce services that provide marginal or no health benefit over less costly alternatives (Bently et al, 2008).

Malpractice law is an aspect of health care policy that complicates the process for doctors, hospitals, and insurers and often causes waste. The malpractice crisis mostly began in the early 1980s when the number of malpractice claims filed against physicians nationwide started to rise. The numbers continued upward at an annual rate of ten percent in the years from 1982 to 1986 (Tussing & Wojtowycz, 1997). Malpractice liability insurance has increased the already-high costs of health care. Malpractice insurance is liability insurance and the purpose is to find fault for wrong doing and deter the wrongdoer by assessing damages (Hall, 1979). So, malpractice insurance is meant to protect the provider in this case.

One of the difficulties in discussing the problem of malpractice is coming to an agreement on the definition because most experts do not know how to define the problem (Hall, 1979). A characterization of the problem by a special advisory panel on medical malpractice in New York provides that, "a physician or surgeon can be held liable for damages resulting from his failure to exercise the degree of

reasonable and ordinary care, diligence, and skill in the diagnosis and treatment of his patient” (Hall, 1979). Thus, medical malpractice may consist of negligence in an action that a reasonable physician would not have taken under the same circumstances.

High insurance premiums for malpractice coverage have led to a number of consequences within the health care industry. First, physicians lessened their risk by leaving certain specialties or have come to avoid certain types of high-risk patients (Tussing & Wojtowycz, 1997). Second, there is the potential of paralysis of the delivery of medical services, as doctors and hospital staff opt for “work slowdowns” to withhold certain types of service or treatment if they are perceived to involve excessive risk (Hall, 1979). Third, physicians have increasingly practiced so-called “defensive medicine” (Tussing & Wojtowycz, 1997). Defensive medicine involves using more diagnostic tests and procedures than needed out of heightened fear of malpractice suits. The U.S. Office of Technology Assessment concluded that fewer than eight percent of all diagnostic tests are performed primarily because of fear of malpractice (Tussing & Wojtowycz, 1997). However, according to the Harvard Law Review’s “Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting,” the annual cost of defensive medicine has grown to roughly \$15 billion. This unnecessary spending qualifies as waste.

There have been attempts by Congress to control the cost of medical malpractice awards that are given out in court. The reforms to the law came in three waves, the first in the mid 1980s, the second in the mid 1990s, and the last in the

early 2000s (Nelson et al, 2007). Each of these reforms capped the amount of damages a jury could give to a plaintiff for pain and suffering. The caps were seen as important due to the perceived high cost and lack of availability of medical liability insurance. Caps on malpractice awards mean insurance premiums would be cheaper for doctors because the potential monetary award lost in a lawsuit would be less, however there is controversy over damage caps and whether they actually reduce malpractice premiums (Nelson et al, 2007).

Some reform critics say high malpractice premiums have driven physicians from their states. Nelson et al (2007) cited a study by Hellinger and Encinosa in 2003 that found states with caps on noneconomic damages, otherwise described as pain and suffering, had 12 percent more physicians per capita than did states without caps. Furthermore, a study by Grofein and Kinney in 1991 found that paid malpractice claims were actually higher in Indiana, which had a cap on total damages, than in Michigan and Ohio, which did not have such caps. Nonetheless, Indiana still had lower malpractice premiums than Michigan and Ohio (Nelson et al, 2007).

The health care industry has also attempted to control malpractice costs. Hospitals have looked to joint hospital-physician liability as opposed to the current system of total liability falling only on the hospital (Harvard Law Review, 1985). In the case of shared liability, malpractice exposure would be limited and hospitals would have less incentive to resist cost-cutting measures. Also, relations between

doctors and hospitals would improve as conflict over fault is tempered (Harvard Law Review, 1985)

## **Cost Saving Measures Already in Place**

As a result of tightening budgets and lower medical reimbursement payments, many hospitals and in-patient facilities are practicing acute care. Acute care lessens the recovery time a patient spends in a hospital or facility and then shifts the burden of long term care from health to social services departments, or to family (Greaves, 1997). Greaves cites the “natural fault line” between medical care and social care. With the exception of care to the elderly, long-term residential medical care in the hospital is now thought of as not deriving from “real” medical needs; thus the state has no obligation to provide for or fund it (Greaves, 1997). That mentality does not only apply to hospitals funded by the state, privately funded institutions also take part in acute care. The elderly are viewed differently, as still having special needs requiring long term residential care, though in homes rather than hospitals.

Medicare Prospective Payment System regulations provide hospitals with stronger incentives to discharge patients sooner (Carroll & Erwin, 1987). The PPS regulations specify that Medicare will reimburse hospitals a set and predetermined dollar amount per case treated. This is different from the retrospective, reasonable-

charge system hospitals had been operating under. The Prospective Payment System was instituted in 1983 and According to Greaves & Erwin (1987) it represents the most dramatic change in the Medicare system since its inception. Health care providers have been concerned that PPS creates a system in which hospitals and physicians may base crucial patient care decisions on financial rather than clinical considerations (Carroll & Erwin, 1987).

The Prospective Payment System creates an incentive for hospitals to decrease a patient's length of stay. Since the patients are being discharged sooner than their care plan may call for, many require post hospital care in long-term facilities. Furthermore, the sicker population that is seen in these long-term facilities requires more extensive and intensive treatments in the post hospitalization period (Carroll & Erwin, 1987). This is not evidence of cost cutting, but cost shifting through patient shifting, as hospitals and treatment centers pass the financial burden on to another institution instead of reducing or eliminating it altogether. Patient shifting could also be manifested by a change in the types of diagnoses or conditions for which patients were admitted to the long-term care facilities from hospitals (Carroll & Erwin, 1987).

The utilization of Practical Nurses and Physician Assistants are seen as cost-saving measures. Hospitals employ people of these professions because they are less expensive than doctors and registered nurses, and are more plentiful. Both positions require less education and training, and thus more people are able to begin a career in these professions. The practical nurses and physician assistants are able to take

care of lower level medical problems and issues while allowing the physician or registered nurse to focus on the most difficult and complex cases. The positions of Licensed Practical Nurse (LPN) and Physician Assistant are often used to deal with a shortage of health care professionals and to increase access to health care for people in underserved areas (Mittman et al, 2002), but the use of LPNs and physician assistants also allows hospitals and clinics to employ a greater number of lower-paid medical staff.

The Licensed Practical Nurse profession grew out of an absence of a standard of knowledge and ability of Practical Nurses (Blaise, 1962). The purpose of the role was to assist registered nurses and help save time by completing time consuming, monotonous tasks that would otherwise keep an RN from more important duties. In the 1990s hospitals downsized nursing staff, and RNs became concerned that their patient load had increased and their proportion among nurses had decreased (Unruh, 2001). The reductions were seen as necessary due to the decline in patient days of care, a decline in revenue, and an increase in competition among payers and providers of health care.

Surveys taken during that decade, including one by the American Journal of Nursing in 1993, found lower vacancy rates and turnover rates, reduced nursing hours, slashed incentive programs, staff reductions by attrition, and actual lay-offs (Unruh, 2001). Changes in the nursing staff skill mix were also noted during the 1990s. There was a decrease in RNs relative to other nursing staff, including LPNs and practical nurses, and an increased use of unlicensed assistive personnel; this

resulted in inadequate RN to patient and licensed nurse to patient ratios (Unruh, 2001). A study by Unruh (2001) showed that in Pennsylvania, the largest decline in nursing staff in the 90s was in LPNs. It is likely the positions were cut because they are a more expendable category of licensed nurse, and although they supplement many RN tasks they still require supervision. The author of the study hypothesizes that RNs felt they were taking on more patients and more tasks because LPNs typically share the case load and without them, the RNs were left to take on a larger share of the duties.

All physician assistants must be associated with a physician and must practice in an interdependent role called “negotiated performance autonomy.” This relationship allows them to staff satellite clinic offices, provide on-call services, and deliver care in rural areas (Mittman et al, 2002). Physicians who work with physician assistants say the advantages outweigh the disadvantages. The physicians can work fewer hours, and spend less time on call, and they are able to delegate many tasks to the assistants so they can provide better service (Mittman et al, 2002). The use of physician assistants is just one mechanism employed to reduce costs and as the use of Health Maintenance Organizations continue to grow, there will be more experiments in health care organization and management (Hooker & Freeborn, 1991).

Health Maintenance Organizations came into use in the 1970’s as part of a federal initiative to restructure medical care delivery (McNeil & Schlenker, 1975). Much of the appeal was that HMO’s could offer their members comprehensive care

at lower costs than conventional fee-for-service practices. Additionally, HMO's were seen as offering benefits that extend beyond their membership in the form of a strong competitive stimulus for improved performance. Researchers had asserted that competition from HMO's would improve the efficiency of health care delivery and help contain rapidly rising medical costs for everyone (McNeil & Schlenker, 1975).

McNeil & Schlenker (1975) hypothesized the number of HMOs grew primarily in response to favorable market conditions and high-level-policy encouragement from the federal government. These market conditions include things like doctor incomes, physicians per capita, and urbanized patient populations. There were favorable policy conditions during this time both at the state level and the federal level. In the 1970's, the federal government funded some HMOs, and such funding actions brought about open discussions among policy experts and scholars about the use of HMOs. State policy conditions included a number of laws that were originally thought to hamper HMO development, however upon further review the laws do not indicate there was any sort of action taken specifically to prevent the growth of HMOs. Several of the laws at the state level required HMOs to have various open-enrollment provisions, which were expected to significantly increase an HMO's costs and decrease its ability to compete. Most of the laws imposed on HMOs during this time reflected the view that competitive market forces cannot be relied on to ensure adequate medical care quality from HMOs.

Health Maintenance Organizations are seen as the primary instruments for managed care in the United States (Clark et al, 2001). By the 1990s, managed care had penetrated the health care market to the point that they were critically influencing the structure of the industry. It led to the consolidation of hospitals and healthcare systems through closings and mergers. This reorganization of work within these facilities is the product of market-driven health care reforms.

There was backlash over the implementation of HMOs in the 1990s. Following that time period there was a trend of disenrollment in favor of other managed care options such as Preferred Provider Organizations. Cooper et al (2006) argued there is plenty of anecdotal evidence on this backlash, but there is little empirical data to support such a claim. The group analyzed data from a series of large nationally representative employer surveys to re-examine changes in enrollment in HMOs and other plan types. Through their research, Cooper et al (2006) found HMO enrollment declined from 31 percent of all enrollees in 1996 to 24 percent in 2003; the steepest declines occurred between 1996 and 1998 and 2000 and 2001. During the 1996 to 2003 time period, PPO enrollment rates almost doubled.

Health Maintenance Organizations are also used with success in Switzerland. Both countries have been using the cost-saving option for decades. In the next section, we will look at cost saving methods in use in Switzerland. In addition to special physician groups, Switzerland also employs other financial austerity measures.

## **Health Care in Switzerland**

While less money is spent on health care in Switzerland, the country is dealing with the undesirable fact of rising costs. Expenditures have increased in the ten years from 1998 to 2008 by 50 to 60 percent (Rovner, 2008). A large part of Switzerland's annual budget needs to be reserved for subsidizing health insurance plans for those who can't afford them. In 2004, the government subsidized the insurance premiums for about a third of the population because they were in financial need (Underwood, 2009). Peter Zweifel, a former professor of health economics at the University of Zurich was quoted on the frustrations of the Swiss parliament as they realized the rising costs. He says those who get the insurance subsidies are not seen as those who will go to the polls and vote for the legislators (Rovner, 2008). However, when the law was crafted, the Swiss populace insisted by referendum that the subsidies be included if there was going to be a requirement for everyone to buy health insurance.

Another aspect of the health care policy in Switzerland that is troubling to some is the fact that health insurance premiums are not linked to income. The insurance plans are governed by the 26 cantons, which means the country has 26

slightly different health care systems (Berchtold and Peytremann-Bridvaux, 2011) and they manage the insurance industry independently of the other cantons while working under federal guidelines. Everyone over the age of 26 pays the same amount regardless of health and wellbeing or income level (Rovner, 2008). Insurers are not allowed to make a profit off of premiums from the basic plans; they can only make profits off supplemental coverage.

The Swiss government subsidizes health care plans for the poor on a graduated basis to make sure everyone can afford to buy into a plan. The government's goal is to keep individuals from spending more than 10 percent of their income on insurance (Roy, 2011). The subsidies lessen the burden since the average Swiss resident spends \$7,141 a year on health either directly or indirectly through taxes (The Telegraph, 2012). Those who wish to acquire supplemental coverage for things like dentistry are free to do so on their own. Those plans are not subsidized (Roy, 2011).

The universal health care system in Switzerland diminished the country's reputation for medical excellence in favor of efficiency. A turning point in the nation's history of health care was the introduction of compulsory insurance in 1994 (Crespo, 2009). In the second half of the Twentieth Century, health care costs rose as a result of technical progress, life expectancy and other social factors. In Switzerland, health care went from consuming 3.5 percent of Switzerland's Gross Domestic Product in 1950 to 8.5 percent in 1990 (Crespo, 2009). In 2009,

Switzerland spent 11.4 percent of its GDP on health care (World Health Organization, 2012).

The compulsory insurance premiums cover only a fraction of Swiss health expenditures. The breakdown of funds is 35 percent of costs covered by compulsory insurance premiums, taxes account for 25 percent, supplementary insurance and contributions from private institutions account for ten percent and the rest is out of pocket (Crespo, 2009). The out of pocket deductibles, or premiums as they're called in Switzerland, can range from \$250 to \$2,100 a year. Additionally, patients pay for 10 percent of outpatient care. In this system, the insurers have much of the power over costs. One unforeseen consequence of the move to compulsory insurance is the emergence of a powerful cartel of health insurers. The 1994 reform called for regular consultation and negotiations between federal health authorities and representatives of health service providers and insurers (Crespo, 2009). Health insurers merged to create a single entity, Santé-Suisse, which now represents the insurers at the federal level.

Crespo is very critical of the reforms in Switzerland, citing a number of other unanticipated consequences of the move to compulsory insurance. The 1994 reforms ushered in federally driven cost-containment measures, such as bed reductions at public hospitals. Those public hospitals reduced bed numbers by six percent between 1998 and 2000. The bed reductions were accomplished through forced mergers of regional hospitals, closure of acute care units, centralizing of more complex technology and rationing of nursing care (Crespo, 2009). The downgrading

of local hospitals inadvertently created inequities in access to specialized units and more advanced medical technology. For example, patients from small towns have a long journey to receiving appropriate care, often getting bounced around from one local hospital to another (Crespo, 2009). Other unforeseen consequences cited by Crespo are regulated lengths of inpatient hospital care, arbitrary bans on certain medical practices, and doctors joining more Health Maintenance Organizations.

As also seen in the United States, a growing part of primary care in Switzerland is provided by networks of physicians and HMOs acting on the principles of gatekeeping. In 2011, an average of one in eight insured persons in Switzerland opted for health care by a doctor in a HMO and about 50 percent of all general practitioners and more than 400 other specialists had joined HMOs (Berchtold and Peytremann-Bridevaux, 2011). Furthermore, 73 out of the 86 physician networks in the country have contracts with the health care insurance companies in which they agree to share budgetary co-responsibility to adhere to set cost targets.

Since the 1990s when HMOs began emerging in Switzerland, two models have formed (Berchtold and Peytremann-Bridvaux, 2011). In the staff model, the insurance company that owns the HMO employs physicians. In the group model, the physicians are the owners of the HMO. The two types of HMO's are similar in their common principle of gatekeeping (Berchtold and Peytremann-Bridvaux, 2011). Patients will always enter into the health care system through the same gate; the

HMO and specialized care or treatment can only be obtained through a referral from the gatekeeper or care manager.

Since HMOs started in 1990, the Swiss government has been able to evaluate them on two-year intervals. The 2010 evaluation was comprised of a survey in the form of an online questionnaire from all physician networks and HMO's in Switzerland under contract to one or several health insurance companies. The questionnaire covered a number of aspects including:

- ◆ The legal form of the network;
- ◆ The number of insured persons cared for by the network;
- ◆ The number of physicians in the network;
- ◆ The financial co-responsibility of the network;
- ◆ Kinds of activities for quality improvement in the network;
- ◆ Kind of contractual cooperation between the network and other care providers;
- ◆ Number and type of preferred provider of the network;
- ◆ The form of management of the network (Peytremann-Bridvaux, 2011).

The survey showed that an average of one out of every eight insured persons in Switzerland, and one out three in the regions in northeastern Switzerland opted for the provision of care by general practitioners in HMO's. That's an increase of 34 percent over 2008 numbers. The survey information also shows a geographic trend in the concentration of HMO's. The northeastern cantons as well as several others, including Geneva and Aargau, show an above average percentage of networks.

Furthermore, the physician networks are still non-existent in some parts of the country especially in the French and Italian speaking areas of Switzerland, with the exception of Geneva. Some portions of Switzerland are isolated by the fact that they do not speak the country's most prevalent language, German. Geneva is the exception in this case possibly because it is the largest and most developed of the non-German regions.

There are some differences doctors in HMOs in Switzerland face when compared to those who are not in HMOs. Doctors in the networks are required to partake in quality management elements. These quality management elements include quality circles, incident reporting, use of guidelines, and disclosure of cost data to health care insurers. Almost half of the networks engage in contractually regulated collaboration with other service providers, with hospitals and emergency services in particular. Additionally, while independent private practice physicians in Switzerland may be paid on a fee-for-service basis, physicians working in HMO's may either be paid fee-for-service or based on salary.

Despite the growth of physician networks in Switzerland, some doctors believe that physician networks reduce costs by constraining access to care or by enabling risk selection. A survey of doctors in Geneva, Switzerland showed that many physicians expressed predominantly negative opinions on the impact of managed care tools such as guidelines, gatekeeping, managed care networks, second opinion requirement, pay-for-performance or utilization review (Berchtold and Peytremann-Bridvaux, 2011).

Peytremann-Bridvaux states that the true importance of the integration of physicians networks will become evident in the future in light of the increase of the prevalence of chronic diseases and the growing complexity of medical treatment. The future of health care in Switzerland needs to target comprehensive services across the care spectrum, standardized care delivery through inter-professional teams, performance management, information systems, governance structure and financing management (Berchtold and Peytremann-Bridvaux, 2011).

There are other health care cost-controlling methods used in Switzerland in the twenty years since passage of the universal health care plan. One such measure employed by the Swiss government is not offering special coverage for the elderly or the poor above a basic subsidized plan. In the United States, the government covers all people of retirement age with Medicare and poorer families to varying degrees through Medicaid. In these cases, the government pays for doctor visits, treatments, prescription drug care and more. However, in Switzerland, all residents are required to buy into a basic policy, regardless of age. That basic policy is the same for everyone as opposed to a different plan for the elderly and a different plan for the poor as seen in America. This requirement offers a substantial cost savings over the model currently used in the United States.

Many have pointed to Switzerland as a model for health care systems (Schwartz, 2009) because the Swiss system does not resemble the bureaucratic, socialized medicine often cited by opponents of universal coverage in the United States. Such socialist models of health care systems ration care, but Switzerland

does not. The Swiss keep overall spending down by regulating drug prices and fees for lab tests and medical devices (Schwartz, 2009). The system also requires patients to share some costs, at a higher level than in the United States, so patients have an incentive to avoid calling for unnecessary tests and treatments.

Furthermore, waits for treatment are few, new expensive drugs are readily available under prescription and medical and nursing care, whether in hospital or at home, is to a high standard (The Telegraph, 2012).

The manner in which the insurance companies in Switzerland operate promotes competition. Within each canton there are usually two or more insurance providers, or sick funds, that totals 80 across the country (The Telegraph, 2012). This means each resident has more than one option for where they will purchase their health insurance plan. Each of the sickness funds has a contract with local hospitals in the canton. Santé-Suisse reviews the contracts on a regular basis, and law defines the terms of the insurance policy so the only variation is pricing that reflects the local risk. Local risk factors include environmental issues like quality of air. Within each canton, the policies differ mainly on deductibles. The standard annual deductible is about \$200 for adults (Underwood, 2009). Individuals can reduce their premiums by electing plans with higher deductibles and then once a deductible has been met, one pays coinsurance of 10 percent of covered expenses. There is a cap on the amount an individual is forced to pay through coinsurance in a year (Underwood, 2009). The insurance companies are allowed to compete on plans based on deductibles and services offered. In addition, they are allowed to compete

on supplemental policies, since they are able to make a profit off the discretionary plans.

Switzerland's compulsory measure is an individual mandate and not an employer mandate, which means each person selects his or her own health insurance plan. In Switzerland there is no national marketplace or insurance exchange where a person can get help deciding on a policy, however there are Internet comparison sites available. To make the decision safer for citizens, each Swiss health insurer must be registered with the Swiss Federal Office of Public Health, which regulates health insurance (Reinhardt, 2004). The office provides quality control in the setting of premiums. Each individual insurer can set their own premiums for a particular type of policy, but those premiums are subject to audit and the office has the power to reduce the proposed premiums if they are deemed to be too high. In addition, the office ensures insurance companies are charging everyone the same premiums, so a 30 years old pays the same as a person who is 80 years old (Reinhardt, 2004). The Swiss compulsory insurance law allows citizens to change insurance companies, and if a person wants to do so the forms are standardized to minimize the cost of switching (Underwood, 2009). However, most people opt to stay with their insurer and seldom switch. A survey revealed that only a minority of the population, mostly younger people, has taken advantage of the ability to switch insurers.

In order to control the costs of tests and procedures ordered by doctors, insurance companies issue warnings. The so-called blue letter cautions a doctor if he

or she is prescribing too many drugs or expensive procedures (Schwartz, 2009). If doctors are not able to justify their treatments they can be forced to repay insurers for a portion of the medical services prescribed. The insurance companies decide what too much spending is by comparing the amount any particular doctor prescribes to the regional median (McManus, 2009). Many doctors dread the blue warning letters, which have been very effective even though estimates show that only about three percent of doctors get them and fewer than one percent actually have to return the money (McClanahan, 2012). In this way, the insurance companies are staying in control of the amount that is spent and the amount that they have to pay for. However, letters of warning could initiate concerns that physicians are more worried about the letters than their patient's well being.

In addition, the Swiss government has taken some measures to control costs. While prescriptions are covered under the basic health insurance plan, the government has insisted that consumers pay, or contribute, a twenty percent co-payment if they want brand-name drugs, rather than the ten percent they pay for generics (Schwartz, 2009). Also, in 2006 the government health office lowered reimbursements across the board for medical devices

## **Conclusion**

The 1994 Federal Health Insurance Act sought to perfect managed competition with full coverage in basic health insurance in Switzerland. The idea was to lay down substantial minimum benefits for all, but encourage competition between insurers (The Telegraph, 2012). The unrelenting rise in costs has been the single biggest disappointment in the Swiss universal health care system (McManus, 2009). According to a report by the Organization for Economic Cooperation and Development, the cost of health care in Switzerland has been increasing steadily, rising by 2.4 percent of GDP between 1990 and 2004. That is above the OECD average increase of 1.5 percent. However, the Swiss health care system has often been cited as a model for which the United States should follow. Every country in Europe guarantees health care for its citizens, but Switzerland, like the United States, chose to do so through the private markets, rather than through socialized medicine (McClanahan, 2012). The Swiss system offers some of the best of what both major political parties in the United States want. As Republicans would prefer, individuals and not employers or the government are in charge of selecting health care plans, which are sold by private insurance companies (Rovner, 2008). On the

other side, Democrats would be pleased that everyone in Switzerland has health coverage and there are subsidies for those who can't afford it. It is not the best or most efficient health care system in the world, but further study of the Swiss health care system is necessary to understand the best way to forge ahead with health care reform. As previously noted, Switzerland ranks on the list of countries for having high health care expenditures, but those expenditures are still well below that of the United States. Thus, the lessons learned from Switzerland could save the United States money and time by implementing policies that have been shown to work in another country.

While Switzerland is ranked second, behind the United States, in terms of OECD countries Gross Domestic Product spending on health care, (OECD, 2006) the Swiss culture may be behind that ranking. Switzerland is a wealthy nation and wealthy nations spend more on medical care. The Swiss use more health care resources than we do in the United States, with more doctors, hospitalizations and certain high-tech procedures (Underwood, 2009). Furthermore, despite the high ranking among OECD countries, Switzerland dedicates only 2.2 percent of its health spending to disease prevention and health promotion compared to an average of 2.7 percent for all OECD countries (OECD, 2006). This gives evidence to a different kind of health care spending in Switzerland.

The Swiss health care system has been successful in ensuring nearly all of the population receives health care coverage. The percentage the country's more than 7.5 million citizens covered by plans is 99.5 (Roy, 2011). Even before the health care

reform, 96 percent of the population was covered. Still, the country is struggling with determining what to do with those who fail to take part in the mandatory system, mainly the poor and recent immigrants (Underwood, 2009). Concessions and allowances are made for people in those two groups. The government provides subsidies for those who can't afford a basic plan. The government gives citizens a three-month grace period after moving to or being born in the country. The insurance mandate is enforced by the individual Swiss cantons using a comprehensive system of reporting combined with substantial penalties (Glied et al, 2007). The government finds those who are not participating in the compulsory insurance mandate through looking at data from unemployment insurance agencies, old-age insurance providers, health insurance carriers and more. One such penalty for those who do not take part in compulsory insurance is forcible compliance. In addition, cantons may impose penalties of thirty to fifty percent above the premium on those who remain uninsured. Also, misrepresenting health insurance coverage is punishable by fines and prison terms (Glied et al, 2007).

The competition between insurance companies in terms of plans and services is meant to help keep costs down. However, not everyone feels this is the case. According to Timothy Stolfus Jost, who is a professor and writer of comparative health care policy, insurers compete with each other to bring down prices in theory, but that doesn't work very well because there is enough wiggle room in the system that insurers are able to cherry-pick the patients who are of good risk as opposed to those at higher risk (Underwood, 2009). So, as long as

insurers are able to control the plan design and have some control over premiums they can manipulate the risk pool.

John Martin, the Director of the Employment, Labour and Social Affairs Directorate in Switzerland has said, “Switzerland will have to develop more cost-effective policies if it wants to better control health expenditure in the future” (OECD, 2006). One recommendation is to limit the possibilities of insurers selecting customers based on their health risk. Instead, health insurers should contract with providers on the basis of quality. Another recommendation is to make changes to the current payment arrangements for both doctors and hospitals because they do not provide strong enough incentives to increase cost efficiency (OECD, 2006). Additionally, investing in prevention and health promotion programs would help Swiss health authorities focus on important public health issues such as tobacco and alcohol consumption. This would promote health and prevent disease in the whole population, by actively targeting people at high risk (OECD, 2006).

Health care in Switzerland has resulted in better health outcomes than in the United States. Life expectancy rates for Swiss residents are higher than in the United States and among the highest in the world. In addition, the quality of care in Switzerland is said to be excellent. Waiting times are not reported to be a serious problem and most people can get the services they need in a timely manner (Underwood, 2009). In addition, modern technology services are readily available.

The Swiss people are generally happy with their health care system. Although residents pay a considerable price tag for their health insurance, they view

their coverage as a necessary safety net (Rovner, 2009). The Swiss health care system has the highest out-of-pocket payments of any OECD country, including the United States. This year, the basic Swiss health insurance policy costs an average of about \$3,800 per adult, with a deductible of about \$300 for the year and a co-payment after that (McManus, 2012). However, Switzerland is seen as a very risk-adverse society; it is a culture where you just don't go uninsured (Underwood, 2009). One popular aspect of the Swiss system is that people get to choose their insurance plan and their doctors. This freedom of choice also means that if a selected doctor says a certain treatment has to be done, then it is done without wait and it is covered (Schwartz, 2009). There is generally no gatekeeper in this system and the Swiss relish the lack of bureaucracy, especially compared with socialized systems in Britain and Germany (Schwartz, 2009).

While Switzerland's health care reform was passed nearly 20 years ago, its structure is similar to the reform passed in the United States in 2010. Neither plan constitutes socialized medicine, nor the plans are said to ration care or make citizens wait long amounts of time before a health procedure is available to them. The United States is already taking part in some cost-saving procedures and methods of care including the utilization of acute care in determining a patient's appropriate care plan, employing more Physician Assistants and Licensed Practical Nurses, and higher participation in Health Maintenance Organizations. Health providers in Switzerland also take part in alternate delivery systems such as HMOs. Grouping physicians together in order to provide more cost effective services has

proved beneficial to both patient and doctor. In Switzerland, the structure of the health insurance system promotes competition, as companies work to provide citizens with the best plans in terms of co-pays and deductibles. Insurance companies also keep costs down by tracking spending on tests and procedures ordered by doctors. If they do not find a doctor's actions to be in line with those of an average doctor they will issue a letter of warning threatening that the doctor will have to provide reimbursement for the procedures if they cannot be justified. In these ways the United States can learn health care policy lessons from Switzerland, a country that has been attempting to control the costs of a universal health care system for many years

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## Appendix A

### Overall health care efficiency ratings in WHO states

1. France
2. Italy
3. San Marino
4. Andorra
5. Malta
6. Singapore
7. Spain
8. Oman
9. Austria
10. Japan
11. Norway
12. Portugal
13. Monaco
14. Greece
15. Iceland
16. Luxembourg
17. Netherlands
18. United Kingdom
19. Ireland
20. **Switzerland**
21. Belgium
22. Colombia
23. Sweden
24. Cyprus
25. Germany
26. Saudi Arabia
27. United Arab Emirates
28. Israel
29. Morocco
30. Canada
31. Finland
32. Australia
33. Chile
34. Denmark
35. Dominica
36. Costa Rica
37. **United States of America**

Source: <http://www.who.int/healthinfo/paper30.pdf>

## Appendix B

### Services Covered by a Basic Insurance Plan in Switzerland

- ◆ Preventative Health Care
- ◆ Examinations and tests requested by your doctor
- ◆ Hospital stays
- ◆ Around 2,500 medicines currently covered
- ◆ Various vaccinations including: tetanus, tick-born encephalitis, human papilloma virus, and influenza for certain age and risk groups
- ◆ Eight examinations to monitor the health and normal development of children of pre-school age
- ◆ Gynecology screening and examinations
- ◆ Mammography to detect breast cancer
- ◆ Maternity examinations, classes, birth, and one post-natal examination
- ◆ Physiotherapy (also known as physical therapy) if prescribed
- ◆ Glasses and contact lenses up to a certain amount
- ◆ Medical aids and devices such as bandages, fixed dressings, inhalers, and respiratory devices up to a certain amount
- ◆ Nursing home care
- ◆ Nutritional advice

Source: "Your Questions, Our Answers" Swiss Confederation, Federal Department of Home Affairs

## Appendix C

### Life Expectancy Comparison by Country Male/female

Japan - 80/86  
San Marino - 82/85  
Australia - 80/84  
**Switzerland 80/84**  
Iceland - 80/83  
Israel - 80/83  
Andorra - 79/85  
Italy - 79/84  
Singapore - 79/84  
Canada - 79/83  
New Zealand - 79/83  
Norway - 79/83  
Sweden - 79/83  
France - 78/85  
Monaco - 78/85  
Spain - 78/85  
Austria - 78/83  
Cyprus - 78/83  
Germany - 78/83  
Greece - 78/83  
Luxembourg - 78/83  
Netherlands - 78/83  
Malta - 78/82  
United Kingdom - 78/82  
Belgium - 77/83  
Republic of Korea - 77/83  
Finland - 77/83  
Ireland - 77/82  
Costa Rica - 77/81  
Denmark - 77/81  
Chile - 76/82  
Portugal - 76/82  
Slovenia - 76/82  
**United States of America - 76/82**

Source: <http://www.who.int/countries/en/>