

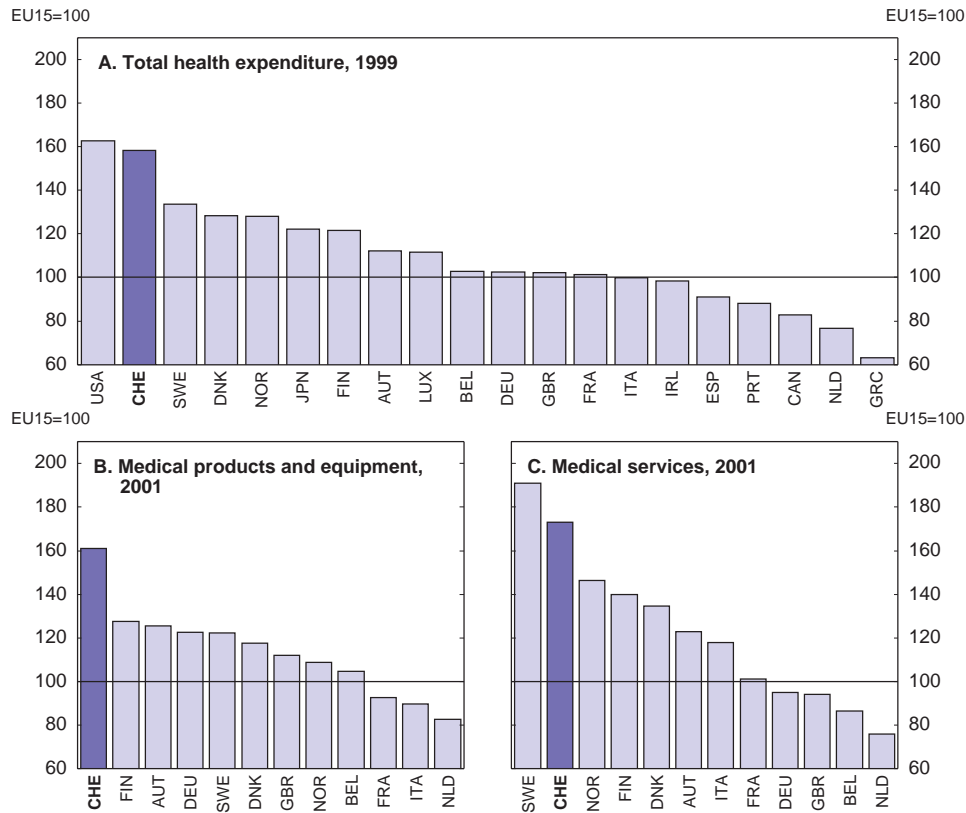


**OECD ECONOMIC SURVEY OF SWITZERLAND:
THE HEALTH SECTOR IS SUFFERING FROM REGULATORY PROBLEMS**

This is an excerpt from Chapter 3 of the OECD Economic Survey of Switzerland, 2003.

The health sector, which accounted for almost 11 per cent of GDP in 2001, is notable for very high prices in international comparison and for being heavily regulated, even if it shares this latter feature with most other OECD countries (**Figure 29**). Demand for medical services is channelled through an insurance system that guarantees individual access to care, *i.e.* limits rationing and ensures solidarity between the insured. Restraining spending and efforts to improve efficiency therefore depend, on the one hand, on the possibilities and incentives of insurers to negotiate advantageous conditions and prices and, on the other, on the incentives that providers have to improve their efficiency. Neither prices nor supply are controlled in the current regulatory environment. In the case of drugs, for example, this is resulting in excessive growth of expenditure (Chapter II and Annex III). As economic factors (salary and interest rate levels) and the demographic and geographical features of the market account for no more than 3 percentage points of the price differential with Germany, the United Kingdom, France and the Netherlands, which ranges from 13 to 38 per cent (Infras/Basys, 2002), the remainder of the differential provides suppliers and distributors with a rent to the detriment of the insured.

Figure 29. Relative health price levels

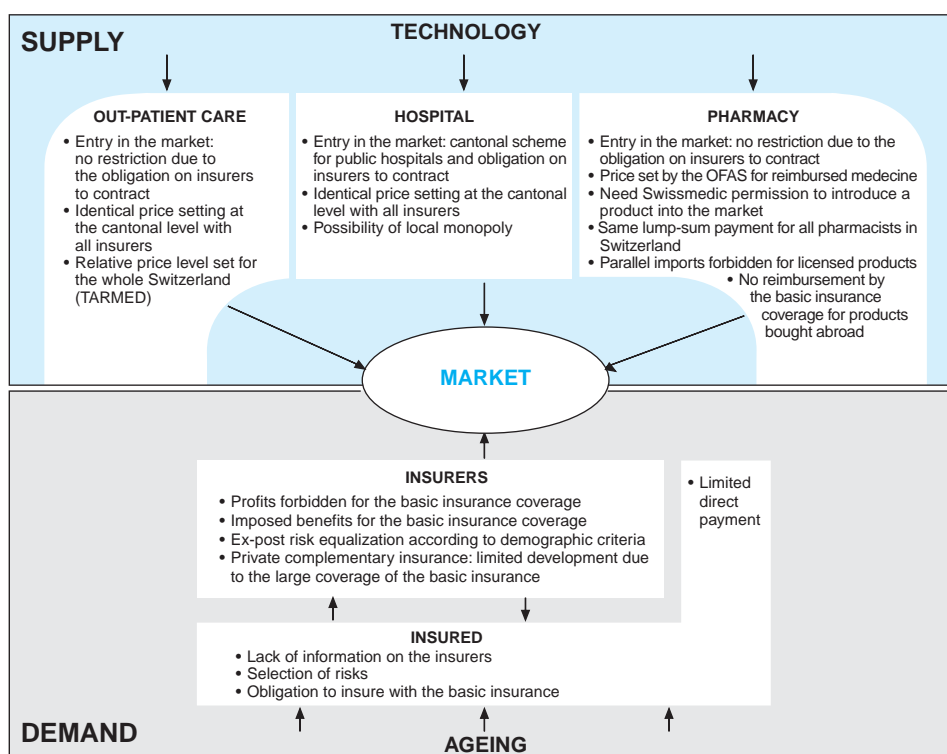


Source: Eurostat and OECD.

There is no effective competition in basic healthcare insurance...

Effective competition between insurers is important to increase their incentives to negotiate advantageous conditions and prices with health providers. However, the compulsory basic health care insurance market is affected by regulatory problems, partly due to the need to promote solidarity (**Figure 30**). Despite the large differences in premiums for the basic standard contracts proposed by numerous private insurance funds, few people change their insurer, which is hardly conducive to a reduction in the differences – in contrast with trends in Germany (OECD, 2003c). The weakness of market mechanisms is partly due to a problem of keeping the insured informed (Colombo, 2001), but it also reflects a tendency for insurers to select risks. It would seem that bad risks have difficulty switching across funds because the latter can select them, for example by indirectly influencing their decisions to join or to leave an insurer.¹ The risk equalisation system designed to prevent such selection needs to be improved. Differences in the state of health of the insured are hard to measure on the basis of solely socio-demographic criteria currently used for equalisation. Moreover, the latter is retroactive, which hardly encourages efficiency since cost overruns in underperforming funds are partly passed on to other insurers (Spycher, 2002). The supply of products with lower cost, like healthcare networks (HMOs), is also penalised by this system, while demand is limited because the reductions in premiums awarded to households for joining HMOs are capped (at 20 per cent for the first 5 years). Lastly, the fact that profits are not allowed to be made on basic insurance curbs incentives to be efficient and innovative. Given this context, risk selection is no doubt the best strategy for insurers if they are to attract the best customers as a way of increasing their gains on the complementary insurance market.

Figure 30. Main impediments to competition in the health care and insurance markets



...or between providers of medical goods and services

Competition between healthcare providers is almost non-existent because of the obligation on insurers to contract, which prevents any control over supply. All the insurers in a given canton have to accept fees from all the hospitals and private practitioners working for the basic insurance system. Moreover, the same prices, negotiated in each canton between associations of insurers and providers, apply *de facto* to all insurance funds. Since the 1996 reform, however, insurers and service providers have been legally able to sign agreements that differ from those concluded between their associations. Until now, though, very little use has been made of that possibility, with the result that price agreements are governed *de facto* by cartels (*Office fédéral des assurances sociales* or OFAS, 2001). Providers are thus not very interested in decentralised negotiations aimed, for example, at developing healthcare networks, while the cantons, which ultimately control hospital prices, seek to deal on an equal footing with the establishments that they subsidise. The end of the obligation to contract in the ambulatory sector could unblock the situation and introduce more competition by encouraging decentralised price negotiations. For that, this reform should affect in a similar way all health providers, those already in the market like those newly trained, who should be submitted to the same threat of no longer being able to practice, rather than favouring *de facto* the incumbents. In the ambulatory sector, increased price flexibility could be coupled with a reform of the pay system for doctors. They are at present being paid per item of treatment, which pushes supply. There should be more room for a system of standard payments per patient, in conjunction with the development of healthcare networks. This would help to prevent the new price system (*Tarmed*)² from becoming even more rigid. However, international experience shows that it is difficult to introduce real competition in the hospital sector (OECD, 2003c), the obstacles stemming in particular from the existence of local hospital monopolies and the difficulty for insurers to negotiate prices for medical treatment without having all the necessary information.

The drugs market is also regulated. The system for authorising the marketing of pharmaceuticals, which is state-controlled as in other countries, is complex (Annex III). The number of authorised drugs seems limited by comparison with other countries, and only 3 per cent of them are generic.³ The financial dependence of the authority responsible for marketing approval *vis-à-vis* pharmaceutical manufacturers has been reduced recently with the creation of *Swissmedic*. Nevertheless, such dependence could still be problematic from the competition point of view (Infras/Basys, 2002). The OFAS, the authority responsible for deciding on medicines reimbursed by the compulsory sickness insurance, which account for nearly 80 per cent of sales,⁴ establishes the upper price limits for all service providers in Switzerland. It fixes these maximum prices on the basis of international and internal comparisons. Since the new Law on Sickness Insurance was introduced in 1996, some convergence towards the European price level has become apparent. On the one hand, the prices of reimbursed drugs, which can be re-evaluated after expiry of patents or after fifteen years, have been lowered by OFAS through a decree.⁵ On the other hand, the rapid development of the generics market favours also downward pressures on prices.⁶ However, drug prices remain often higher than in other countries, the differences being generally due to the appreciating exchange rate. The considerable economic weight of the pharmaceutical industry,⁷ which in addition has an advantage in terms of information, seems also to weigh on its position towards OFAS, given the existing obstacles preventing effective competition from imports in this sector. The first such obstacle is the ban on parallel imports for patent-protected products, which make up 60 per cent of the market. Since 2002, the new law on therapeutic products has however authorised imports of drugs whose patents have expired. In 2000, COMCO asked the Federal Council to authorise the reimbursement of drugs and medical products purchased abroad if they are cheaper than in Switzerland and do not pose any public health risk, which is currently not possible with basic insurance. There is no decision yet. The removal of these import barriers would encourage a fall in the prices of pharmaceuticals. The introduction of the principle of prescribing active substances rather than branded products would also make doctors more independent of the pressure exerted by the pharmaceuticals industry, and it would promote the prescription of generic drugs. To that end, it would also be necessary to suppress the possibility granted to doctors by some cantons to deliver directly medical products. Lastly, there is also room for further enhancing the new system of remunerating pharmacists based since July 2001 on a lump sum payment (rather than on margins) set at the same level throughout Switzerland. This new system contributed to diminish the price of drugs by 10 per cent on average. The lump sum payment, the introduction of which meant that pharmacists' incomes could be separated from the products prescribed, should be negotiated on a decentralised basis.

NOTES

1. According to different surveys, only 2 per cent of insured people, mainly the young who are a good risk, changed insurers in 2000, and the level of switching decreased between 1997 and 2000 (Colombo, 2001). Insurers can encourage bad risks to leave or, alternatively, seek to attract good risks by proposing additional options at interesting prices. .
2. Tarmed, which is to come into force in early 2004, will be replacing the 26 cantonal systems currently in use. It establishes prices for medical services throughout the whole of Switzerland on the basis of a point system which takes into account the time spent on each patient, the competence of the doctor and the type of treatment provided. The value of the point has to be negotiated at cantonal level.
3. In 2000, 7 000 drugs were authorised, 2 500 of which were reimbursed under the basic sickness insurance scheme, whereas the French social security system reimbursed 20 000 products.
4. Part of the drugs reimbursed by the compulsory sickness insurance is prescribed by hospitals, which are managed by the cantons. These pharmaceutical products are also bought at cheaper prices. The share of medicines reimbursed by the compulsory sickness insurance, outside hospitals, reaches 60 per cent of sales.
5. Switzerland is the only European country which re-evaluates the prices of reimbursed drugs after expiry of patents or after fifteen years.
6. The market of generics rose by almost 40 per cent in the first half of 2003 (year-on-year) and this increase will probably be stronger in the second half of 2003.
7. 20 per cent of Swiss exports are pharmaceuticals, while Novartis, Roche and Serono have a 7 per cent share of the world market.