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MANAGED CARE: PRESCRIPTION FOR FAILURE? LESSONS FROM SWITZERLAND

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Introduction

On 17 June 2012, a majority of 76 percent of Swiss voters said ‘No’ to a revision of the Federal Health Insurance Act (KVG) that would have made Managed Care (MC) the dominant variant of health insurance in Switzerland (for details, see Interpharma 2012). In economic terms, MC involves a degree of vertical integration; usually, a health insurer signs an exclusive contract with a group of physicians who commit to adhere to certain cost-saving or quality-enhancing norms. In turn, the insured are directed to this group of providers (see below for more details). The MC bill had passed Parliament in September 2011 with a comfortable majority, but initiators of a popular referendum (mainly physicians) had been able to collect the necessary 50,000 signatures (this amounts to about one percent of the country’s voting population).

For many outside observers, this ‘No’ came as a surprise. After all, MC had been introduced in the early 1990s, even before the promulgation of the new Health Insurance Act that survived a popular referendum to become effective in 1996. After a slow start, MC picked up market share after 2005, reaching 47 percent by 2010 (Federal Office of Public Health 2011). And contrary to the United States, where major employers (who contract health insurance on behalf of their work force) had strongly promoted MC, triggering the so-called Managed Care backlash, the choice between options in basic health insurance has been a true consumer choice since 1996, with employer involvement only in supplementary coverage, if at all.

So, how did this failure come about? This article first explains MC and then moves on to expound the potential of MC to increase the efficiency of health-care delivery. However, MC comes at a price in that it requires consumers to give up free physician choice, while physicians have to give up payment by fee-for-service. Next, it presents experimental evidence suggesting that both Swiss general practitioners and consumers require substantial compensation to accept these restrictions. The conclusion is that the ‘No’ of June 2012 is due to a political failure in that politicians sought to relieve the public purse through MC without respecting citizens’ preferences.

What is Managed Care?

In 1945, industrialist Henry Kaiser had construction work to do in remote areas of the north-western United States, where healthcare providers were few and far between. His solution was to hire physicians, paying them a salary for treating his workers. This solution inspired President Nixon, who in 1973 signed a law mandating major employers to include at least one so-called Health Maintenance Organization (HMO) plan in the choice of health insurance plans offered to their workers (Starr 1982). The objective was to curb the rising cost of health care impinging on the public purse, and this has remained the objective of politicians in favor of MC ever since. Accordingly, the HMO variant of MC is particularly attractive to them since it completely turns around the incentives of physicians. Earning a fixed income, (possibly augmented by a bonus if the plan makes a profit), they now have an interest in seeking out less costly treatment alternatives, rather than tending towards over-treatment. Indeed, they now would want to keep the insured healthy to begin with (hence the term ‘Health Maintenance Organization’). In order to ensure that these lower-cost alternatives are, in fact, pursued by patients, members of a Managed Care Organization (MCO) are assigned to a ‘gatekeeper’, usually a general practitioner who is in charge of coordinating care; and referrals to a specialist or to a hospital are subject to the gatekeeper’s consent.



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The change of labels from HMO to MCO is not coincidental, but reflects a change of structure. HMOs met with resistance from the medical profession from the start and were denigrated as providers of low-quality care. However, they were increasingly also resisted by the insured, who resented their lock-in effect. When seriously ill, patients often preferred to be treated by a provider who did not participate in the HMO. In response to this 'HMO/MC backlash' (Marquis, Rogowski, and Escarce 2004), more flexible forms of MC were developed in the 1990s. On the demand side, some of them allow MC patients to call on outside providers on the condition that they cover the extra cost out of pocket. On the supply side, physicians formed so-called Independent Practice Associations (IPAs) designed to offer health insurers discounts on fee-for-service care. They achieve these discounts by having their members adhere to second-opinion programs in the case of referrals to specialists and hospitals, or even accept utilization review that singles out high-cost physicians for monitoring. Some of these associations negotiate directly with major employers (recall that they purchase health insurance on behalf of their workers), in which case they are called Preferred Provider Organizations (PPOs). About 90 percent of the US population is currently insured by some type of MC; however, this high share is not entirely the result of consumer choice, but also of States assigning their indigent citizens covered by the Medicaid program to MCOs in an attempt to relieve their public purse.

In the case of Switzerland, social health insurers were allowed to create HMOs starting in the early 1990s, based on a waiver of the existing law. With the Health Insurance Act of 1994, they generally obtained the right to develop new products provided that they kept their promise of lowering costs and increasing efficiency. However, the so-called any-willing-provider clause, giving all physicians the right to treat and bill patients of all Swiss social health insurers, remained in effect. With healthcare providers strongly preferring conventional fee-for-service practice (Zweifel 2011), health insurers have been facing considerable difficulties in building MCOs. Integration of the two lines of command, financial and medical, also proved to be challenging. Many of the early pioneers gave up, dissolving their MCO or selling it to a competitor. Accordingly, the market share of MCOs was slow to rise, only reaching some eight percent by 2005. More recently, nudged by continuously rising premiums, Swiss con-

sumers have turned to MC-type contracts (mostly of the more flexible varieties rather than HMOs), pushing their present market share up to almost 50 percent (Federal Office of Public Health 2011).

How Managed Care can contribute to efficiency

According to the literature on economic policy, four properties can be used to describe the efficiency of an economy, (1) least-cost production of a given set of goods, (2) matching of production with consumer preferences, (3) dynamic efficiency, i.e. adjustment of (1) and (2) to changes in supply and demand and (4) the absence of rents that would permit producers to deviate from (1) to (3). These conditions will be applied to the healthcare sector based on the argument that this sector is part of the general economy – an argument which, of course, is very alien to healthcare professionals.

1) *Contribution of MC to least-cost production:* To the extent that fee-for-service payments contain a margin in excess of marginal cost, physicians have an incentive to sell more services than medically indicated (Zweifel and Breyer 1997, ch. 7). MC usually involves a fixed payment per year per enrolled person (a so-called capitation), which does away with this incentive. Since gatekeepers also have to cover the cost of specialist and hospital services from their capitation, they seek to reduce the number of referrals. Unlike their US counterparts, Swiss MCOs cannot negotiate special hospital rates because the Cantons (Swiss member states) are the owners of the public hospitals, which account for most of the beds. MC nevertheless holds the promise of contributing to least-cost production of healthcare services in Switzerland. This also was the main reason why its lawmakers passed the MC bill in 2011; they saw MC as a way of stabilizing health insurance contributions and of relieving both cantonal and federal budgets (note that there are means-tested subsidies for health insurance, jointly financed by the Cantons and the Confederation).

Indeed, Lehmann and Zweifel (2004) found the short-term health care expenditure (HCE) of MC-type insurance contracts to be up to 50 percent lower than that of their fee-for-service counterparts. Panel data supplied by a major Swiss health insurer permitted to use three years of observations (1997 to 2000) to determine whether an

enrollee was above or below his or her conditional expected value of HCE. This deviation served as an indicator of latent health status in the HCE regression for the year 2000. One-third of the reduction in HCE associated with HMO-type contracts could be attributed to risk selection effects in this way, leaving two-thirds as an incentive effect. In the case of IPA-type contracts with no utilization review, only one-third of savings in HCE was attributable to changed provider incentives. While total savings were estimated to be smaller by Trottmann, Zweifel and Beck (2012), IPA-type contracts again were associated with ‘true’ savings amounting to one-third.

2) *Contribution of MC to closer matching of consumer preferences:* The Act of 1994 mandates cost sharing in the guise of an annual deductible, combined with a ten percent rate of coinsurance applied to total outlays exceeding the deductible. The innovation was that health insurers could offer deductibles ranging from CHF 300 to 1,200 (which have now been increased to CHF 400 to 2,500).¹ Since MC-type contracts were exempted from coinsurance, MC was a welcome addition to the menu of choices for those who are risk averse with regard to wealth, but only moderately risk averse with regard to health, causing them to accept the lock-in effect of MC. The Act of 1994 also admits bonus options for no claims in analogy to experience rating in auto insurance, for example. However, in its ordinance, government slashed an initial surcharge of ten percent on the premiums of conventional contracts for fear of bonus offers serving as an instrument of risk selection (although a risk adjustment scheme was already in place). Risk adjustment (RA) punishes an insurer (and ultimately its members) whose population consists of above-average shares of young and male individuals (for some unexpected side effects of RA, see Schoder, Sennhauser, Zweifel 2010). As a result of this surcharge, bonus options have a market share of less than one percent.

3) *Contribution to dynamic efficiency:* Whenever the set of goods and services produced is not fixed, but can be extended thanks to innovation, there is a trade-off between static and dynamic efficiency. Specifically, by granting patent protection public policy seeks to encourage dynamic efficiency; in

return, the temporary monopoly enjoyed by innovators violates the ‘price equals marginal cost’ rule of static efficiency. In the context of medical innovation, the trade-off is slightly different, revolving around the balance between process, product, and organizational innovation (Zweifel, Breyer, and Kifmann 2009, ch. 14). Due to insurance coverage, new medical technology comes at the same (almost zero) out-of-pocket cost to patients as the older one. Therefore, patients tend to prefer (and service providers, to propose) the most advanced treatment available, without much regard for cost. Compared to product innovation, cost-reducing, process and organizational innovation have traditionally been little pursued in the healthcare sectors of industrial countries in general, and of Switzerland in particular.

The case of the canton Basel-Country is instructive. In 2009, the canton decided to upgrade and extend a hospital that was built in the 1960s, less than 5 km away from its border with the canton of Basel-City, whose several hospitals (one of them a renowned university clinic) always had sufficient capacity. More generally, Swiss public hospitals have been adopting expensive medical technology without seeking the co-operation with institutions in their vicinity, resulting in an unparalleled density of MRI and CT scanners, for example. According to Rovere and Barua (2012), there are 12.6 MRI per one million inhabitants in densely populated Switzerland, compared to 8.4 in Canada. In the case of CT scanners, the difference is even more striking, with the Swiss density at 29.6 per million, twice the value of Canada (14.6 per million). In this context, MC constitutes an organizational innovation that is expected to enhance providers’ interest in process innovation (Zweifel 2005).

By redressing the balance between the three types of innovation, MC may enhance dynamic efficiency. However, when it comes to the Swiss hospital sector, its effect is limited because MCOs are not permitted to vertically integrate public hospitals. MC nevertheless serves to speed up adjustment to changes in supply and demand in ambulatory healthcare, since it creates incentives for healthcare providers to contribute to the success of the health insurance plan. MC therefore injects ‘competition between systems’ into the healthcare sector, causing providers to be more responsive to the changing preferences of their clientele lest the

¹ CHF (Swiss franc) equals roughly 0.9 USD at current exchange rates; for more detail on Swiss health insurance, see Kreier and Zweifel 2011.

MCO lose market share, while making insurers more prudent purchasers of healthcare services.

4) *Ensuring the 'no rents' condition*: Producers who enjoy rents have little incentive to comply with criteria (1) to (3). They have leeway to deviate from least-cost production, do not have to closely match the goods and services offered to consumer preferences, and need not strive to adjust to ever-changing demand and supply conditions in order to survive in the market. Barriers to entry are known to create this leeway. Clearly, barriers to entry are as prominent in Swiss healthcare markets as those in any other industrial country (see, for example, Götte and Hammes 1998). While MC cannot do away with barriers to entry, it does establish a benchmark against which established service providers can be measured.

Warnings from experimental evidence

As noted above, the market share of MC remained low in Switzerland well past 2000, giving rise to the suspicion that MC did not conform to average Swiss preferences. Therefore, a so-called discrete choice experiment (DCE) involving some 1,000 residents was conducted in 2003. DCEs are a tool for measuring preferences for goods that are not (yet) on the market; in this present case these are MC contracts that would better match consumers' preferences. Usually, the status quo is fixed in terms of a set of attributes, while several alternatives with changed levels of these attributes are proposed to partici-

pants in the experiment, who have to indicate whether they want to stay with the status quo or whether they prefer the alternative. By making the price to be paid one attribute, one can infer the (marginal) willingness to pay (WTP) for an attribute using econometric methods (see, for example, Louviere, Hensher and Swait 2000). In the present context, the attributes were (1) physician choice (free in the status quo vs. constrained under MC), (2) access to newest medical technology (immediate vs. delayed by two years under MC), (3) coverage of pharmaceuticals (unconstrained vs. generics or cheapest alternative available), (4) Drugs for minor complaints (unconstrained vs. exclusion from the drug benefit), (4) hospital choice (community hospitals vs. regional health centers under MC), and (5) annual contribution to social health insurance (unchanged vs. up to +/- 50 CHF per month). It is worth noting that the variation in attribute (5) may not be realistic given an average contribution of CHF 3,600 (300 per month) at the time; however, it serves to move respondents back and forth between the status quo and the alternatives. If they stay with the status quo, little can be learned about their preferences.

The estimated WTP values are displayed in Table 1 (see also Zweifel, Telser, Vaterlaus 2006). They are all negative, implying that on average, Swiss consumers need to be compensated to accept the restrictions in choice imposed on them by MC. Giving up free physician choice (a defining characteristic of MC) would have to be compensated by up to 38 percent of average premium (amounting to some EUR 2,030 per year). MC could also be used to direct patients to

Table 1

Willingness-to-pay (WTP) values for MC-type attributes

WTP in € / year 1 € = 1.55 CHF (2003)	WTP Switzerland	WTP Germany	WTP Netherlands
Physician list, cost criteria only	-792*	n.a.	n.a.
Physician list, quality criteria	-408*	n.a.	n.a.
Physician list, both cost and quality criteria	-324*	-115*	-346*
Delay of 2 years in the introduction of new therapies	-503*	n.a.	n.a.
Generics only in drug benefit	-23	n.a.	n.a.
Exclusion of drugs for minor complaint from drug benefit	-46	n.a.	n.a.
Regional hospital units only	-286*	n.a.	n.a.
Constant	-451*	-500*	-256*

Notes: Figures for Switzerland refer to 2003, for Germany to 2005, and for the Netherlands to 2006.

* indicates significance at the 5 percent level or better. The WTP of -346 is the estimated WTP of the Dutch to revert from gatekeeping to free physician choice.

Source: The author.

hospitals providing better care at lower cost, in keeping with established medical opinion claiming that larger hospitals achieve better quality of treatment because of their higher volumes of surgery (Birkmeyer, Siewers and Finlayson 2002). However, this view is refuted by consumers; indeed, such a concentration would have to be compensated for by about 18 percent of average premium. In hindsight, a preference for community hospitals is not so astonishing. It suffices to imagine a future mother considering having her baby 50 km away from home, in one of these ‘efficient’ specialized units. Would her husband, her relatives, and her friends be likely to show up with that bunch of flowers?

One could argue that, in spite of the detailed scenario description in the DCE, most participants did not understand what MC meant, since its market share was still low in 2003. However, evidence from the Netherlands suggests otherwise. In another DCE fielded in Germany and in the Netherlands (where gatekeeping is part of the status quo), substantial WTP for returning to the status quo prior to free physician choice was found (MacNeil Vroomen and Zweifel 2011; Zweifel, Rischatsch and Leukert 2010). Interestingly, this WTP value even exceeds the compensation requested by German participants for moving away from their status quo of free physician choice and towards gatekeeping (see Table 1).

A case of political failure

The MC bill as passed by the Swiss parliament was inconsistent from the outset, because it contained a provision to force social health insurers to create MC plans everywhere – even in a canton like Uri. This canton, situated in the valley leading up to the Gotthard pass, has a population of 30,000, living at 1,400m altitude and higher, hours away from the hospital of the capital town Altdorf when the freeway is clogged by vacationers on their way to Italy. At the same time, physicians were to retain the right to conventional fee-for-service practice, which they strongly prefer (Rischatsch and Zweifel 2012).

With the market share of MC increasing anyway, Swiss politicians could abstain from nudging consumers towards MC. However, the promise of savings (to the public purse, of course) is too much of a lure to them. In its fall 2012 session, Switzerland's federal parliament already came up with a new, less restrictive MC bill. It remains to be seen whether this

bill will be challenged again by a popular referendum; and if so, whether it will survive the challenge.

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