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# Federalism and the Financing of Health Care in Canada and Switzerland: Lessons for Health Care Reform in the United States

*Paul J. Donahue\**

## I. INTRODUCTION

Among the myriad of variables which health care reform in the United States must address is how reform should, at the level of the theoretical ideal, and must, at the level of pragmatic politics, take into account the federal organization of the government. As the research which underlies this article has again reminded the author, the American situation is unique. The lessons foreign models teach may not be relevant to the United States, and if relevant, may not be easy to apply. Nevertheless, it would be foolish to shape health care reforms with the potential to affect American society as profoundly as any other governmental initiatives in the history of the Republic without trying to learn whatever we can from the experience of others. The collapse in 1994 of the Clinton administration's major initiative for national health care reform heightens the importance of examining the experience of other federal states.<sup>1</sup> Health care reform, at least for the foreseeable future, is likely to occur in small steps, taken both by the federal government and by the states.<sup>2</sup>

It is at least plausible to hypothesize that the experience of other federally organized states is more relevant to the American situation than that of more unitary states. That hypothesis forms the first principle of selection for this study. Further, the choice of Canada seemed clear because discussion of the Canadian health care system has been such an important part of the American health care debate. The

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<sup>1</sup> For an analysis of health care economics which includes a discussion of the theoretically ideal health care reform and of how closely the Clinton proposals approximated the ideal, see Paul J. Donahue, *Federal Tax Treatment of Health Care Expenditures: Is It Part of the Health Care Problem?* 46 WASH. U.J. URB. & CONTEMP. L. 141 (1994).

<sup>2</sup> See *id.*

limited and recently changed role of government in Switzerland, and its high level of health care spending, suggested that Switzerland too would have important lessons to offer American policy makers, and the results have fully justified that expectation.

This article discusses each country separately. Within each section, I begin with a very brief discussion of political history and structures. I then discuss where constitutional responsibility for health care lies and describe the division of responsibility and authority for health care financing between the federal government and those of the States or Cantons. A description of the origins and evolution of government financing of health care follows.

Documentation of the history and content of legislation affecting government health care financing and of the political dynamic which shaped it is one of the most important objectives of this article. I found as I read many articles discussing health care financing, most notably about health care in Canada, that references to primary sources were few. I found myself wondering whether or not the interpretations I was reading were accurate, and realizing that I did not have enough information to decide. I decided that there was considerable value simply in setting forth the history of health care financing legislation in a reasonably comprehensive way that would permit others to evaluate the judgments I made about that legislation. Further, the history of legislation and of the political dynamic is the source most likely to provide lessons for proponents of health care reform in the United States.<sup>3</sup>

Lastly, this article discusses the extent and nature of government intervention in health care financing, and assesses the effect of government intervention on total health care spending. In conclusion, I generalize briefly the basis of the individual sections, and offer some observations on what the American health care reform effort might learn from those in Canada and Switzerland.<sup>4</sup>

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<sup>3</sup> I should make clear at the outset what the reader would in any case soon discern, that I believe that economic efficiency requires fundamental changes in health care financing in the United States. In the context of the current system, I believe that managed care has made an important contribution to increasing the cost-effectiveness of health care expenditures.

<sup>4</sup> In a subsequent article, the author plans to extend his analysis to Australia and Germany.

## II. CANADA

### A. *History*

Permanent European settlement of what became Canada began with the arrival in 1604 of French colonists under the leadership of Samuel Champlain of Brouage.<sup>5</sup> After spending the years 1604–1607 at the mouth of the Bay of Fundy, on July 3, 1608, Champlain founded the city of Quebec, the oldest site of continuous European habitation in Canada.<sup>6</sup> The settlement gained solidity with the arrival of more colonists and cattle in 1634.<sup>7</sup> A further infusion near the end of the 1660s and subsequent small and intermittent immigration from France<sup>8</sup> grew into the modern French Canadian population of approximately seven million, nearly 25% of Canada's population of 28.8 million.<sup>9</sup>

A long period of French and British conflict, conducted on two continents, resulted in the cession of French Canada to Great Britain in 1763.<sup>10</sup> English settlement in Nova Scotia and in the province of Quebec and in the region of Lake Ontario received a substantial impetus by the flight of United Empire loyalists from the British colonies which became the United States.<sup>11</sup> A more important source was the settlement of the rich agricultural lands of Ontario by American immigrants.<sup>12</sup> In 1791, British North America was divided into Upper and Lower Canada, roughly corresponding to modern Ontario and Quebec.<sup>13</sup> Fifty years later, in an effort to put the English stamp more firmly on Quebec, and to introduce representative government, this partition was reversed.<sup>14</sup> The fur trade prompted the settlement of central Canada, by way of Hudson's Bay,<sup>15</sup> and of what became British Columbia, both overland from the east and by sea.<sup>16</sup> The gold rush

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<sup>5</sup> See J. Bartlet Brebner, *Canada, A Modern History*, in THE UNIVERSITY OF MICHIGAN HISTORY OF THE MODERN WORLD 28–29 (Allan Nevins & Howard M. Ehrmann eds., 1960).

<sup>6</sup> See *id.* at 28–29, 30.

<sup>7</sup> See *id.* at 36.

<sup>8</sup> See *id.* at 46.

<sup>9</sup> See Telephone Interview with Denise Maynard of Statistics Canada, Ottawa, quoting data from the 1996 and 1991 censuses [hereinafter Maynard Interview].

<sup>10</sup> See Brebner, *supra* note 5, at 72.

<sup>11</sup> See *id.* at 107.

<sup>12</sup> See *id.* at 109.

<sup>13</sup> See *id.* at 109–10.

<sup>14</sup> See *id.* at 222–23, 241–42.

<sup>15</sup> See Brebner, *supra* note 5, at 245.

<sup>16</sup> See *id.* at 249–52.

along the Fraser River gave a tremendous boost to the settlement of British Columbia.<sup>17</sup>

The British North American Act of 1867 created the Dominion of Canada by uniting Nova Scotia, New Brunswick, Quebec, and Ontario, and provided its constitution.<sup>18</sup> Central Canada joined the Dominion in 1870, with the creation of the Province of Manitoba and the North West Territories.<sup>19</sup> Saskatchewan and Alberta were created out of the territories in 1905.<sup>20</sup> British Columbia was admitted in 1871, and Prince Edward Island in 1873.<sup>21</sup> Newfoundland did not become part of Canada until 1949.<sup>22</sup>

## B. Constitution

Canada is a monarchy whose sovereign is that of the United Kingdom.<sup>23</sup> The sovereign is represented in Canada by a Governor-General.<sup>24</sup> The constitution is silent as to the manner of appointment and tenure of the Governor-General, but since 1930, all Canadian Governors-General have been selected by the Canadian Prime Minister, who also determines the Governor-General's tenure.<sup>25</sup> The upper House of Parliament, the legislative authority, is the Senate, whose members are appointed for life by the Governor-General.<sup>26</sup> Provincial representation moderates the weight given to population.<sup>27</sup> The lower house is the House of Commons, where the membership is allocated on the basis of population.<sup>28</sup> The executive power of government rests in the cabinet, which was not mentioned in the Constitution Act, 1867,<sup>29</sup> and especially in the Prime Minister, who exercises in practice most of the authority constitutionally assigned to the Governor-General.<sup>30</sup>

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<sup>17</sup> See *id.* at 252.

<sup>18</sup> See *id.* at 289.

<sup>19</sup> See *id.* at 292.

<sup>20</sup> PETER W. HOGG, CONSTITUTIONAL LAW OF CANADA 229 (3d. ed. 1992 (bound ed.)).

<sup>21</sup> See Brebner, *supra* note 5, at 293.

<sup>22</sup> See *id.* at 497-98.

<sup>23</sup> See HOGG, *supra* note 20, at 232 nn.14-16.

<sup>24</sup> See *id.*

<sup>25</sup> See *id.*

<sup>26</sup> See CAN. CONST. (Constitution Act, 1867) §§ 24, 29; HOGG, *supra* note 20, at 1308-09.

<sup>27</sup> See CAN. CONST. § 22; HOGG, *supra* note 20, at 1307.

<sup>28</sup> See CAN. CONST. § 22; HOGG, *supra* note 20, at 1307.

<sup>29</sup> See HOGG, *supra* note 20, at 234.

<sup>30</sup> See, e.g., *id.* at 233.

The drafters of the Constitution Act, 1867, intended Canada to have a strong central government.<sup>31</sup> Residual governmental power belongs to the federal government.<sup>32</sup> Early on, the federal government exercised power over the provinces like that of an imperial government over its colonies.<sup>33</sup> Due in part to judicial decisions which gave a narrow interpretation to the principal federal powers, the residuary and trade powers, and a wide interpretation to the principal provincial power, over property and civil rights, and in part to other tendencies in Canada, however, the current Canadian system is less centralized than that either of Australia or the United States.<sup>34</sup>

Canada is a country of remarkable physical, climactic, and ethnic diversity, as one would expect based on its history.<sup>35</sup> Particularly important is the linguistic and cultural division between Quebec and the rest of Canada.<sup>36</sup> These diversities, especially ethnic diversity, have no doubt contributed to the functionally greater role that the provinces play in Canada's government than do the states of the United States.

### C. *Responsibility for Health Care*

Health care services fall exclusively within the areas of provincial responsibility.<sup>37</sup> Section 92(7) of the Constitution Act, 1867 gives the provinces authority over hospitals.<sup>38</sup> An expansive reading of the "property and civil rights in the province" clause of Section 92(3) of the Constitution Act, 1867 gave the provinces authority over the medical profession, as well as over a contributory insurance program.<sup>39</sup> Through use of conditional grants of federal funds, however, the federal government prompted the introduction of provincial insurance both for hospitalization and medical services.<sup>40</sup>

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<sup>31</sup> See *id.* at 108.

<sup>32</sup> See *id.* at 435–36.

<sup>33</sup> See *id.* at 110.

<sup>34</sup> See HOGG, *supra* note 20, at 110–11.

<sup>35</sup> See Brebner, *supra* note 5, at 515–18.

<sup>36</sup> See *id.* at 518.

<sup>37</sup> See, e.g., CAN. CONST. § 92(7), (3).

<sup>38</sup> See *id.* § 92(7).

<sup>39</sup> See HOGG, *supra* note 20, at 149 & n.33.

<sup>40</sup> See *id.* at 149–50.

#### D. *Origins of National Health Insurance*

Although government previously had been involved in health care delivery, it was the economic pressures of the depression and of the Second World War that made public health insurance a national issue.<sup>41</sup> In 1945, the national government made a proposal which was unacceptable to the wealthier provinces.<sup>42</sup> Although voluntary prepayment plans moved quickly to fill the void, the absence of such plans in Saskatchewan led the Co-operative Commonwealth Federation (CCF) government there to introduce a universal hospital insurance plan in 1947.<sup>43</sup> British Columbia followed suit in 1949, and Alberta in 1950.<sup>44</sup> When Newfoundland became part of the Dominion in 1949, half its population was already covered by a government program,<sup>45</sup> established by the British-appointed government that preceded Newfoundland's entry into Canada and modeled on that for the Scottish Highlands and Islands.<sup>46</sup>

Not only did government-provided hospital insurance take root as the result of provincial initiative, but so did the enactment of a national program.<sup>47</sup> As a result of a proposal by the Prime Minister of Ontario at the 1955 Conference on Tax Agreements, the national government was forced to enact the Hospital Insurance and Diagnostic Services Act.<sup>48</sup>

#### E. *Hospital Insurance and Diagnostic Services Act*<sup>49</sup>

The Hospital Insurance and Diagnostic Services Act is of astonishing brevity for major social legislation, little over five pages long.<sup>50</sup> Section

<sup>41</sup> See Malcolm G. Taylor, *The Canadian Health Care System 1974-1984*, in *MEDICARE AT MATURITY: ACHIEVEMENT, LESSONS AND CHALLENGES* 3 (Robert G. Evans & Gregory L. Stoddart eds., 1986).

<sup>42</sup> See *id.* at 4. The proposal involved granting the national government sole authority to tax incomes in return for the provision by the national government of a wide range of social insurance programs. See *id.*

<sup>43</sup> See *id.*

<sup>44</sup> See *id.*

<sup>45</sup> See *id.*

<sup>46</sup> See Gordon H. Hatcher, et al., *Health Services in Canada*, in *COMPARATIVE HEALTH SYSTEMS, DESCRIPTIVE ANALYSES OF FOURTEEN NATIONAL HEALTH SYSTEMS* 88 (Marshall W. Rattel ed., 1984).

<sup>47</sup> See *id.* at 88-89.

<sup>48</sup> See *id.* at 5.

<sup>49</sup> Hospital Insurance and Diagnostic Services Act, ch. 28, 1956-1957 S.C. 155 (Can.).

<sup>50</sup> See *id.*

3 authorizes the Minister of National Health and Welfare to enter into agreements with the provinces to contribute to the cost of hospital insurance furnished by a provincial program.<sup>51</sup> Section 4 sets the contribution rate by blending the national and provincial costs and reimbursing the provinces in the amount of half the blended rate multiplied by total hospital costs for covered persons.<sup>52</sup>

In order for a provincial program to qualify, it needed do no more than:

1. specify the insured services to be provided,
2. specify the amount of authorized charges,
3. include a schedule of hospitals,
4. establish an administrative mechanism,
5. make insurance available to all provincial residents on uniform terms and conditions,
6. assure adequate monitoring of hospital standards,
7. maintain adequate financial records, and
8. provide for recovery of provincial expenditures where another party had legal liability by way of damages for the insured's hospital costs due to negligence or other wrongful act.<sup>53</sup>

#### F. *Medical Care Act*<sup>54</sup>

Provincial initiative was also important to expansion of government support beyond hospital services to other health care services.<sup>55</sup> Saskatchewan's CCF government used the federal revenues it received due to the Hospital Insurance and Diagnostic Services Act to honor its fifteen year commitment to a comprehensive health insurance plan.<sup>56</sup> Also playing a role was the commitment of the out-of-power Liberals to a federally subsidized, provincially administered program at their January 1961 national policy conference.<sup>57</sup>

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<sup>51</sup> See *id.* § 3.

<sup>52</sup> See *id.* § 4.

<sup>53</sup> See *id.* § 5, pts. 1, 2.

<sup>54</sup> Medical Care Act, ch. 64, 1966–1967 S.C. 563 (Can.).

<sup>55</sup> See *e.g.*, Taylor, *supra* note 41, at 5.

<sup>56</sup> See *id.* Introduction of the plan provoked a doctor's strike, ultimately resolved by a compromise which preserved the program, and a short-term exodus of physicians from the province. See ROBERT G. EVANS & MAUREEN M. LAW, *THE CANADIAN HEALTH CARE SYSTEM, WHERE ARE WE; HOW DID WE GET HERE?* 10–11 (1991).

<sup>57</sup> See Taylor, *supra* note 41, at 5.



In part to counter this threat to its role in fashioning health care policy, the Progressive Conservative government of John Diefenbaker named a Royal Commission chaired by the Chief Justice of Saskatchewan to make recommendations.<sup>58</sup> The Royal Commission reported in June 1964.<sup>59</sup> Despite its conservative political parentage, and to the surprise of the medical and insurance industries, the Commission recommended a comprehensive range of benefits that would be federally subsidized and provincially administered.<sup>60</sup>

The Medical Care Act is quite similar in form to the Hospital Insurance and Diagnostic Services Act, but more direct in its mandate.<sup>61</sup> It would be entirely possible to design a modest program of incentives to promote voluntary insurance administered by private entities and still to qualify for the matching grants of the Hospital Insurance and Diagnostic Services Act.<sup>62</sup> As we shall see, a system of incentives to promote voluntary purchase would be much less likely to qualify, and arguably would have been intended not to qualify, for the grants of the Medical Care Act.<sup>63</sup>

While the Medical Care Act does not quite achieve the brevity of the Hospital Insurance and Diagnostic Services Act, it is still very short, only eight pages long.<sup>64</sup> The Act grants contributions from the federal fisc toward the cost of qualifying provincial plans to provide medical care services insurance.<sup>65</sup>

The first qualification requirement is that:

the plan is administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province . . . that is responsible in respect of the administration and operation of the plan to the government of the province or to a provincial minister designated by the government of the province for such purpose, and that is subject in respect of its account and financial transactions to

<sup>58</sup> See *id.* at 6; EVANS & LAW, *supra* note 56, at 11.

<sup>59</sup> See Taylor, *supra* note 41, at 6; EVANS & LAW, *supra* note 56, at 11.

<sup>60</sup> See Taylor, *supra* note 41, at 6; EVANS & LAW, *supra* note 56, at 11.

<sup>61</sup> See Medical Care Act, ch. 64, 1966-1967 S.C. 563, 563 (Can.); Hospital Insurance and Diagnostic Services Act, ch. 28, 1956-1957 S.C. 155, 155 (Can.).

<sup>62</sup> See Hospital Insurance and Diagnostic Services Act, ch. 28, 1956-57 S.C. 155, § 5, pts. 1, 2 (Can.).

<sup>63</sup> See Medical Care Act, ch. 64, 1966-1967 S.C. 563, 563 (Can.).

<sup>64</sup> See *id.*

<sup>65</sup> See *id.* § 3.

audit by such person as is charged by law with the audit of the accounts of the province.<sup>66</sup>

This requirement appears to envision sole government administration, a "single-payer" to dredge up the adjectival phrase we are so accustomed to associate with medical care insurance in Canada. Perhaps no province would have been able to win the concurrence of the federal cabinet to any other type of program.<sup>67</sup>

It could be plausibly argued, however, that the pre-1966 Swiss system which is discussed below, a system of government incentives to the voluntary purchase of insurance from mutual companies with close government regulation, or indeed a program like that proposed in 1994, by the Clinton administration, meets the formal requirement of administration and operation by a public authority.<sup>68</sup> Those possibilities appear to lie within the scope of provincial freedom of action as defined in Section 4(2), though the language of the section is sufficiently opaque as to leave some doubt:

Notwithstanding paragraph (a) of subsection (1), a plan established by an Act of the legislature of a province does not fail to satisfy the criteria set forth in that paragraph by reason only that it authorizes the designation by the provincial authority of an agency or agencies to carry out any responsibility in connection with the receipt and payment of accounts rendered for insured services or authorizes any agency or agencies so designated to receive premiums or other accounts payable under the provincial law for remission to the provincial authority, if under the provincial law it is a condition of any such designation that all individual accounts so rendered to which the designation extends are subject to assessment and approval by the provincial authority and that the amounts to be paid in respect thereof shall be determined by the provincial authority.<sup>69</sup>

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<sup>66</sup> See *id.* § 4(a).

<sup>67</sup> See *id.* § 7(1). Section 7(1) leaves the determination of doubtful cases of qualification to the Governor in Council, which in a parliamentary system like that of Canada means the federal cabinet. See *id.*; HOGG, *supra* note 20, at 234.

<sup>68</sup> See H.R. 3600, 103d Cong. (1993); S. 1757, 103d Cong. (1993).

<sup>69</sup> Medical Care Act, ch. 64, 1966–1967 S.C. 563, § 4(2) (Can.).

The point here is that the federal legislation should be construed to permit a greater degree of diversity in health care delivery systems than has in fact developed.

The second requirement echoes the "uniform terms and conditions" requirement of the Hospital Act, but goes somewhat further.<sup>70</sup> It requires:

the payment of amounts . . . in accordance with a tariff of authorized payments established pursuant to the provincial law or in accordance with any other system of payment authorized by the provincial law, on a basis that provides for reasonable compensation for insured services rendered by medical practitioners and that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons.<sup>71</sup>

The preferred "uniform term" is a provincial fee schedule, but other payment mechanisms appear to be acceptable as long as they do not affect the out-of-pocket payments of the insured. Once again, a choice among health plans offering a standard plan would appear to qualify.

The third requirement is that the provincial plan cover at least 90% of insurable residents initially and 95% in the third and subsequent years.<sup>72</sup> This appears to rule out, for practical purposes, incentives and a voluntary program, although, as we shall see, the Swiss achieved 99% participation with a program that was largely voluntary.<sup>73</sup> Finally, the plan must provide a waiting period of no longer than three months and must provide continuation of coverage during that period.<sup>74</sup> The contribution scheme parallels that for hospitalization plans.

### G. *Established Program Financing Arrangement (EPFA)*<sup>75</sup>

In an era of rapidly increasing medical costs, the open-ended nature of the federal financing commitment led to dissatisfaction at the fed-

<sup>70</sup> See Hospital Insurance and Diagnostic Services Act, ch. 28, 1956-1957 S.C. 155, § 5(2)(a) (Can.); Medical Care Act, ch. 64, 1966-1967 S.C. 563, § 4(1)(b) (Can.).

<sup>71</sup> Medical Care Act, ch. 64, 1966-1967 S.C. 563, § 4(1)(b) (Can.).

<sup>72</sup> See *id.*

<sup>73</sup> See *La Reforme du Système de Santé en Suisse*, Office fédérale des assurances sociales 5 (Feb. 4, 1994) [hereinafter *Swiss Reform*].

<sup>74</sup> See Medical Care Act, ch. 64, 1966-1967 S.C. 563, § 4(1)(d) (Can.).

<sup>75</sup> Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, ch. 10, 1976-1977 S.C. 301 (Can.) [hereinafter 1977 Federal-Provincial Financing Act].

eral level with the system of matching contributions.<sup>76</sup> At the provincial level, there was a desire for greater flexibility in the use of federal funds.<sup>77</sup> In 1977, the federal government imposed on the provinces a program of revenue-sharing and cash grants which replaced cost-sharing, the EPFA.<sup>78</sup> In the years after 1977, the federal government reduced its contributions under EPFA on three separate occasions, and in 1990, implicitly established a schedule for phasing out the cash grant part of EPFA.<sup>79</sup>

#### H. *The Canada Health Act*<sup>80</sup>

Despite its declining financial contribution, the federal government acted in 1984 to establish greater control over program financing.<sup>81</sup> The federal Parliament enacted unanimously the Canada Health Act.<sup>82</sup> The Act consolidated federal health care legislation by repealing both the Hospital Insurance and Diagnostic Services Act and the Medical Care Act,<sup>83</sup> and reenacting and stiffening the operative qualification provisions of those Acts. Section 3 of the Act states that: “[T]he primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well being of residents of Canada and to facilitate access to health services without financial or other barriers.”<sup>84</sup>

Section 7 lists the requirements for federal funds.<sup>85</sup> They are: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility. The requirement of public administration, spelled out in Section 8, is essentially the same as that contained in the Medical Care Act.<sup>86</sup> It does nothing to restrict the legality under the Medical Care Act of a broader range of health care delivery systems than fee-for-service, for which I argued above.<sup>87</sup> “Comprehensiveness”

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<sup>76</sup> See EVANS & LAW, *supra* note 56, at 12.

<sup>77</sup> See *id.*

<sup>78</sup> See *id.* at 12–13.

<sup>79</sup> See *id.* at 13.

<sup>80</sup> Canada Health Act, ch. 6, 1983–1984 S.C. 273 (Can.).

<sup>81</sup> See *id.*

<sup>82</sup> See *id.*

<sup>83</sup> See *id.* § 32.

<sup>84</sup> *Id.* § 3.

<sup>85</sup> See Canada Health Act, ch. 6, 1983–1984 S.C. 273, § 7 (Can.).

<sup>86</sup> See *id.* § 8; Medical Care Act, ch. 64, 1966–1967 S.C. 563, § 4(1) (Can.).

<sup>87</sup> See Canada Health Act, ch. 6, 1983–1984 S.C. 273, § 8 (Can.); Medical Care Act, ch. 64, 1966–1967 S.C. 563 (Can.).

means that the provincial plan must cover all health care services provided by authorized providers to insured persons.<sup>88</sup> "Universality" means just that: 100% of the provinces' residents, other than members of the military services or of the Royal Canadian Mounted Police, prisoners, or persons resident for fewer than three months, must be insured.<sup>89</sup> This requirement goes beyond the 95% participation required by the Medical Care Act.<sup>90</sup> "Portability" limits the maximum waiting period to three months and requires reimbursement of medical expenses incurred by residents while temporarily outside the province.<sup>91</sup> The "accessibility" criterion reiterates the requirements found in the Medical Care Act.<sup>92</sup>

Section 18 enacted a financial penalty on provinces that permitted balance billing. Section 19 enacted a parallel penalty for provinces which levied user charges. These provisions effectively eliminated both practices. The implementation of the balance-billing ban in Ontario led to a doctors' strike which lasted for twenty-five days in 1986.<sup>93</sup> Lack of support among the public and among doctors themselves led to its abandonment.<sup>94</sup>

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<sup>88</sup> See Canada Health Act, ch. 6, 1983-1984 S.C. 273, § 9 (Can.). On its face, this does not appear to allow the provinces to exclude purely optional medical services, like cosmetic surgery. See *id.* However, Evans and Law state that the requirement extends only to "medically necessary" services, which excludes elective cosmetic surgery. See EVANS & LAW, *supra* note 56, at 19. Further, "medical" is narrowly defined, so that provinces can exclude coverage of all non-physician practitioner costs. See *id.* Although, as Evans and Law correctly point out, a more expansive approach to "medical necessity," along the lines of utilization review, could be used to contain costs, this is not an approach that has succeeded even when the government program stressed cost-effectiveness more explicitly than the Canadian program does. See *id.*

<sup>89</sup> See Canada Health Act, ch. 6, 1983-1984 S.C. 273, § 10 (Can.). As pointed out by Evans and Law, this requirement means that provincial governments cannot condition eligibility on premium payments. See EVANS & LAW, *supra* note 56, at 18. Further, in a uniform public system with no choices in alternate delivery mechanisms available, premiums reduce to a regressive poll tax. See *id.* at 18 n.10. However, that would not at all be the case where individuals can choose among programs meeting nationally imposed minimum standards, as in Switzerland and in the Clinton proposal for health care reform in the United States. See H.R. 3600, 103d Cong. (1993); S. 1757, 103d Cong. (1993). Where individuals are free to choose "richer" coverage, it is important both for reasons of cost-containment and fairness that they bear fully the cost of any additional health care consumption that they choose. See Donahue, *supra* note 1, at 141, 161-63.

<sup>90</sup> See *supra* note 72 and accompanying text.

<sup>91</sup> See 1984 Canada Health Act, ch. 6, 1983-1984 S.C. 273, § 11 (Can.).

<sup>92</sup> See *id.* § 12; *supra* note 70 and accompanying text.

<sup>93</sup> See EVANS & LAW, *supra* note 56, at 13-14.

<sup>94</sup> See *id.*

## I. *Canada Health and Social Transfer*<sup>95</sup>

The Canada Health and Social Transfer (CHST) was part of the 1995 Budget Bill. CHST replaced federal funding for health care provided under the EPFA, as it had been reduced by changes subsequent to initial enactment.<sup>96</sup> CHST continued the trend by limiting the potential growth in federal support for the provincial programs still further.<sup>97</sup>

If a province conditions the existence or form of coverage upon a minimum period of residence, in excess of the three month period permitted by Section 11(a) of the Canada Health Act, Section 19 of CHST reduces the cash contribution to that province.<sup>98</sup> If reductions, required by the Canada Health Care Act, to a province's federal health care contributions are in excess of the amount of the contributions, Section 23.2 permits the federal government to reach other funds which are due that province.<sup>99</sup>

## J. *Ontario Health Insurance Act*<sup>100</sup>

As one could deduce from the brevity of the federal legislation alone, one cannot speak accurately of a "Canadian" program of government health insurance. Rather, in Canada, there are provincial programs of government health insurance that conform to the federal requirements for a federal subsidy.<sup>101</sup> We examine here Ontario's health care program.

<sup>95</sup> Federal-Provincial Fiscal Arrangement Act, ch. F-8, R.S.C. (1985) (Can.) [hereinafter Canada Health and Social Transfer].

I am grateful to Renee St-Jacques, Senior Chief, Federal-Provincial Relations Division, Department of Finance Canada, who not only provided me with statutory materials dealing with the Canada Health and Social Transfer, but also discussed its economic effect with me in a series of emails and telephone conversations.

<sup>96</sup> See EVANS & LAW, *supra* note 56, at 12.

<sup>97</sup> See Canada Health and Social Transfer, *supra* note 95, § 15. Section 15 contains formulas to determine the total entitlement and to allocate the total to the provinces. See *id.* The total entitlement for the 1997-98 through 1999-2000 fiscal years was \$25.1 billion. See *id.* The formula for determining a subsequent year's entitlement is to multiply the preceding year's entitlement by (B minus C). See *id.* § 17. B is the cube root of the quotient obtained by dividing the Gross Domestic Product for the calendar year ending in the preceding fiscal year, by the Gross Domestic Product for the calendar year ending in the fourth preceding calendar year. See *id.* C is 0.02 for the 2000-01 fiscal year, 0.015 for the 2001-02 fiscal year and 0.01 for the 2002-03 fiscal year. See *id.*

<sup>98</sup> See Canada Health and Social Transfer, *supra* note 95, § 19.

<sup>99</sup> See *id.*; Canada Health Act, ch. 6, 1983-1984 S.C. 273 (Can.).

<sup>100</sup> Ontario Health Insurance Act, R.S.O., ch. H.6 (1990) (Can.).

<sup>101</sup> See, e.g., *id.*

Section 2(1) makes the Minister of Health the public authority responsible for the Ontario plan for purposes of federal legislation.<sup>102</sup> Section 4 vests administrative responsibility in a General Manager.<sup>103</sup> Section 5 establishes a Medical Review Committee, Section 6, Practitioner Review Committees, and Section 7, a Medical Eligibility Committee to advise the General Manager.<sup>104</sup> Section 8 creates an Appeal Board to hear appeals from administrative decisions of the General Manager.<sup>105</sup>

Section 13 states that insureds have the right to choose their own physician and that physicians have the right to refuse to treat persons insured under the Act.<sup>106</sup> Section 14 prohibits private contracts of insurance for services covered under the Ontario Health Insurance Plan.<sup>107</sup> Section 15 permits assignment of benefits provided the provider does not bill the insured and accepts Plan payment as payment in full.<sup>108</sup> Section 30 provides the subrogation required to qualify for federal subsidy by the Medical Care Act.<sup>109</sup>

The Ontario Health Insurance Act continues the Ontario Health Insurance Plan which appears to have been established initially by the

<sup>102</sup> See *id.* § 2(1).

<sup>103</sup> See *id.* § 4.

<sup>104</sup> See *id.* §§ 5, 6, 7.

<sup>105</sup> See Ontario Health Insurance Act, R.S.O., ch. H.6, § 8, (1990) (Can.).

<sup>106</sup> See *id.* § 13.

<sup>107</sup> See *id.* § 14. Evans and Law conclude, from the absence of a private market for medicine in Canada, that "'private' markets for medicine can persist only where they can be supported directly or indirectly by a public system." See EVANS & LAW, *supra* note 56, at 19. This conclusion is patently false, as the nearby example of the United States ought to suffice to show. Rather, as Kenneth J. Arrow suggests, the risk of loss posed by illness is the quintessentially insurable risk. See *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 945 (1963). This provision prohibits a private market in health care insurance. See *id.* It is this prohibition, rather than the existence of a public insurance system, which explains the absence of a private medical care market in Canada. See *id.* Where such insurance is permitted, as in Britain, private medical care markets do exist. See *id.*

<sup>108</sup> Ontario Health Insurance Act, R.S.O., ch. H.6, § 15 (1990). Acting in concert with this provision, Chapter H.3, Section 2 of the Health Care Accessibility Act complies with the mandate of the Canada Health Act that the provinces prohibit balance billing. See Health Care Accessibility Act, R.S.O., ch. H.3, § 2 (1990). Section 2 prohibits physicians who do not accept assignment of benefits under the Ontario Plan from charging or accepting payment greater than that which the Plan would have provided. See *id.* Further, it prohibits the physician from accepting payment from the insured until the physician has been notified that the Plan has reimbursed the insured, without explicit consent by the insured. See *id.* Section 8 makes violation of Section 2 an offense punishable by a fine of \$2,000 and permits private prosecution. See *id.* §§ 2, 8.

<sup>109</sup> See Ontario Health Insurance Act, R.S.O., ch. H.6, § 30 (1990) (Can.); Medical Care Act, ch. 64, 1966-1967 S.C. 563 (Can.).

Health Services Insurance Act.<sup>110</sup> The Health Services Insurance Act establishes the “Health Services Insurance Plan . . . for the purpose of providing for insurance of the costs of insured health services and such other services on a non-profit basis on uniform terms and conditions available to all residents of Ontario,”<sup>111</sup> parroting the conditional language of the federal Hospital Insurance and Diagnostic Services Act.<sup>112</sup> Every resident of Ontario has the right to become an insured person on application to the Health Insurance Registration Board (Board).<sup>113</sup> Benefits are payable for all services provided by health care practitioners other than those which qualify for reimbursement under the Hospital Services Commission Act.<sup>114</sup>

The Health Services Insurance Act requires employers of fifteen or more persons (“mandatory groups”), and permits employers of five to fifteen persons, to collect from their employees the premiums required by the Act.<sup>115</sup> The employees are primarily responsible for payment, but may bargain with their employers for an employer contribution.<sup>116</sup> Section 13 establishes three classes of premiums—(1) single, (2) insured with one dependent, and (3) insured with two or more dependents—but leaves the amount of the premium to be established by regulation.<sup>117</sup> Sections 17 and 18 give the Board sweeping authority to grant premium subsidies as it wishes, both permanent and temporary, through the promulgation of regulations.<sup>118</sup>

The provincial government determines how much the plan will pay for each covered service by establishing by regulation a fee schedule for benefits under the plan.<sup>119</sup> The Act also gives the provincial Minister of Health the authority to enter into arrangements for paying providers on a basis other than fee-for-service.<sup>120</sup> Where a provider intends to

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<sup>110</sup> See *id.*; Health Services Insurance Act, R.S.O., ch. 200 (1970) (Can.).

<sup>111</sup> Health Services Insurance Act, R.S.O., ch. 200, § 3 (1970) (Can.).

<sup>112</sup> See Hospital Insurance and Diagnostic Services Act, ch. 28, 1956–1957 S.C. 155, § 5, pts. 1, 2 (Can.).

<sup>113</sup> See Health Services Insurance Act, R.S.O., ch. 200, § 6 (1970) (Can.).

<sup>114</sup> See *id.* § 7.

<sup>115</sup> See Health Services Insurance Act, R.S.O., ch. 200, §§ 9, 10 (1970) (Can.).

<sup>116</sup> See *id.*

<sup>117</sup> See *id.* § 13.

<sup>118</sup> See *id.* §§ 17, 18.

<sup>119</sup> See *id.* § 21.

<sup>120</sup> See Health Services Insurance Act, R.S.O., ch. 200, § 20, (1970) (Can.). Thus, although fee-for-service is the dominant form of physician payment, at least the legislation early provided for delivery alternatives. See Hatcher, et al. *supra* note 46, at 92.



charge an insured more than the plan will reimburse, the provider must inform the insured before the service is provided.<sup>121</sup>

The Act gives the provincial government extraordinary authority to define critical elements of the plan by regulation. The Lieutenant Governor in Council may make regulations:

- (a) providing for enrollment,
- (b) defining dependents,
- (c) governing premium collection and information returns,
- (d) setting premium amounts,
- (e) determining subsidy qualifications,
- (f) defining eligible services, and
- (g) determining claims procedures,<sup>122</sup>

as well as on a variety of other important administrative matters.

#### K. *Enrollment*

As the brevity of the relevant legislation requires, and as the grant of regulatory authority permits, the Ontario Health Insurance Plan emerges only in Ontario regulations.<sup>123</sup> It is only in the regulation that the degree of mandatory participation first emerges.<sup>124</sup> Employees who are part of a mandatory group must generally be members of that group for insurance purposes.<sup>125</sup> Recipients of public assistance are enrolled as a result of actions required to be taken by program administrators.<sup>126</sup> Persons who are not compelled to participate may participate voluntarily by paying the premium required.<sup>127</sup> Full or partial premium subsidies are available for low-income applicants.<sup>128</sup> Canadian enrollment and financing requirements deserve the attention they are receiving as possible models for the United States, even if other aspects of the Canadian system do not.

<sup>121</sup> See Hospital Services Insurance Act, R.S.O., ch. 200, § 22 (1970) (Can.).

<sup>122</sup> *Id.* § 32.

<sup>123</sup> See Ontario Health Insurance Plan, R.R.O., Reg. 452 (1980) (Can.).

<sup>124</sup> See *id.*

<sup>125</sup> See *id.* § 3(1).

<sup>126</sup> See *id.* § 28(1).

<sup>127</sup> See *id.* § 23(1).

<sup>128</sup> See Ontario Health Insurance Plan, R.R.O., Reg. 432, § 27 (1980) (Can.).

## L. *Benefits*

Regulation 432, Section 37(5) makes chronic nursing home care a covered service.<sup>129</sup> Section 43 provides acute nursing home care.<sup>130</sup> Section 44 makes home care services covered services.<sup>131</sup> Section 38 covers the following inpatient services: (1) room and board at standard rates, (2) necessary nursing provided and paid for by the hospital, (3) diagnostic and therapeutic laboratory, radiologic, and other tests, (4) prescribed drugs, and (5) use of operating or delivery rooms, including anesthetic.<sup>132</sup>

Section 39 covers the following outpatient services: (1) diagnostic tests, (2) radiotherapy, occupational therapy and physiotherapy, (3) speech therapy prescribed by a physician, (4) diet counseling when prescribed by a physician, (5) the hospital component of all other outpatient services, (6) home renal dialysis, (7) home hyperalimentation, and (8) home treatment of hemophilia.<sup>133</sup> Some dental, optometric, chiropractic, osteopathic and chiropodist services are covered.<sup>134</sup> Services provided by physicians are covered unless excluded.<sup>135</sup> Physicians are reimbursed based on a fee schedule.<sup>136</sup>

## M. *Health Care in Practice*

The Canadian health care system is extremely popular with the public. Gallup polls in 1982 and 1984 showed that 80% of the Canadian people were either "very satisfied" or "quite satisfied" with their health care system.<sup>137</sup> Indeed, the unanimous passage of the Canada Health Act, with its bans on user fees and balance billing, was testimony of the most eloquent sort to the popular appeal of the Canadian

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<sup>129</sup> See *id.* § 37(5). The Canada Health Act permits co-payments for chronic nursing home care, in an important exception to its ban on user charges. See EVANS & LAW, *supra* note 56, at 22 n.15. Nevertheless, in this author's opinion, provision of any support for chronic nursing home care not tied to income puts the Canadian system ahead of current proposals for reform in the United States.

<sup>130</sup> See Ontario Health Insurance Plan, R.R.O., Reg. 432, § 43 (1980) (Can.).

<sup>131</sup> See *id.* § 44.

<sup>132</sup> See *id.* § 38.

<sup>133</sup> See *id.* § 39.

<sup>134</sup> See *id.* §§ 46–50.

<sup>135</sup> See Ontario Health Insurance Plan, R.R.O., Reg. 432, §§ 53(2), 54, 55(1) (1980) (Can.).

<sup>136</sup> See *id.* § 67.

<sup>137</sup> See John K. Iglehart, *Health Policy Report, Canada's Health Care System*, 315 N. ENG. J. MED. 202, 203 (1990) [hereinafter Iglehart I].

approach.<sup>138</sup> John K. Iglehart, writing in 1986, in the *New England Journal of Medicine*, stated: "Canada's health insurance program resembles a pressure cooker that is building up steam on a hot stove."<sup>139</sup> Three-and-a-half years later, he wrote that his original analogy held, but that the heat had been turned up.<sup>140</sup> In 1990, Canada had the second-highest per capita health care spending, exceeded, of course, only by the United States.<sup>141</sup> It also had the second highest compound growth rate for the period 1980-1990.<sup>142</sup>

A recent article which appeared in the *New York Times* reinforced Iglehart's gloomy assessment of the delivery of health care in Canada.<sup>143</sup> This purely anecdotal article focused on provider dissatisfaction and on the possibility of long waits for elective surgery.<sup>144</sup> In contrast to this negative portrayal, according to an *Angus Reid Report* published in March 1996, 74% of Canadians think that their health care system is good or excellent.<sup>145</sup> This is a drop of only 6% compared to the early 1980s, when health care costs were skyrocketing.<sup>146</sup>

What makes the relative stability of consumer satisfaction especially remarkable is that health expenditure data now tells a very different story from that at the beginning of the decade. Health care expenditures as a percent of Gross Domestic Product (GDP) were 9.1% in 1990, rose to 9.8% in 1991, peaked at 10.1% in 1992 and 1993, and fell to 9.7% in 1994.<sup>147</sup> At 9.7% of GDP, Canada has fallen behind the most recent percentages for Switzerland, 9.9%, and France, 9.8%.<sup>148</sup>

The federal contribution to the cost of provincial government health expenditures has declined from a peak of 44.6% in 1979, to 40.0% in

<sup>138</sup> See *id.* at 207.

<sup>139</sup> *Id.* at 203.

<sup>140</sup> See John K. Iglehart, *Health Policy Report: Canada's Health Care System Faces Its Problems*, 322 N. ENG. J. MED. 562, 568 (1990).

<sup>141</sup> George J. Schieber et al., *International Comparisons of Health Spending*, 13 HEALTH CARE FINANCING REV. 5, tbl. 3 (1992).

<sup>142</sup> See *id.*

<sup>143</sup> See Anthony DePalma, *Doctor, What's the Prognosis? A Crisis for Canada*, N.Y. TIMES, Dec. 15, 1996, at A3.

<sup>144</sup> See *id.*

<sup>145</sup> See Email to the author from Gary Holmes, Research Assistant, Health Canada (Mar. 14, 1997).

<sup>146</sup> See POLICY AND CONSULTATION BRANCH, HEALTH CANADA, NATIONAL HEALTH EXPENDITURES IN CANADA, tbl. 2A (Jan. 1996) [hereinafter NATIONAL HEALTH EXPENDITURES]. Health care costs rose 16.12%, 18.04%, 16.90%, 10.53% and 7.74% for the years 1980 through 1984, respectively. *Id.*

<sup>147</sup> See *id.* at 28, tbl. 2.

<sup>148</sup> See *id.* at 20.

1985, to a low of 32.2% percent in 1992.<sup>149</sup> The percentage federal contribution rose slightly in 1993 and 1994, to 32.3% and 33.0% respectively.<sup>150</sup> This happened because Established Programs Financing increases due to population growth outpaced increases in provincial health care spending.<sup>151</sup> This progressive cost-shifting made the provinces the payors of residual health care costs and, thus, appears to have transferred the incentive for cost-containment entirely to the provinces. It was inevitable that it would take some experience dealing with the burden of residual payment in an era of high health care cost inflation before the provinces could formulate plans, and achieve the political consensus required, for effective cost-containment programs.

It is also true that payment of non-hospital providers using fee schedules has moderated the rate of cost increases.<sup>152</sup> Administrative costs have tended to rise only in line with inflation.<sup>153</sup> Although an increase in utilization has increased total non-hospital provider incomes faster than inflation,<sup>154</sup> the use of global budgets for hospitals has resulted in a steady decline in acute care utilization and in less rapid proliferation of high-cost technology.<sup>155</sup>

The provinces now appear ready to take further action to contain costs. Since the effectiveness of any specific tactic for controlling utilization tends to erode over time, Canadian provincial governments are increasingly exploring wider use of global budgets to reduce their health care costs.<sup>156</sup> By 1991, Quebec and British Columbia had already imposed explicit caps on total outlays for physician services.<sup>157</sup> Global caps for physician expenditures have spread beyond Quebec and British Columbia to include Manitoba.<sup>158</sup> Prince Edward Island, Nova Scotia, Ontario, and Quebec restrict payments to individual physicians based on their total income.<sup>159</sup>

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<sup>149</sup> See *id.* at 52.

<sup>150</sup> See *id.*

<sup>151</sup> See NATIONAL HEALTH EXPENDITURES, *supra* note 146, at 35.

<sup>152</sup> See John K. Iglehart, *Health Policy Report, Canada's Health Care System*, 315 N. ENG. J. MED. 778, 782 (1986); EVANS & LAW, *supra* note 56, at 35.

<sup>153</sup> See EVANS & LAW, *supra* note 56, at 35.

<sup>154</sup> See *id.* at 36.

<sup>155</sup> See *id.* at 37.

<sup>156</sup> See *id.* at 36.

<sup>157</sup> See *id.*; see also John K. Iglehart, *Health Policy Report, The United States Looks at Canadian Health Care*, 321 N. ENG. J. MED. 1767, 1771 (1989).

<sup>158</sup> See EVANS & LAW, *supra* note 56, at 36.

<sup>159</sup> See *id.* Above a specified amount, physicians' reimbursement is sharply reduced, in some

## N. *Administrative Expenses in a "Single-Payer" System*

An antipathy to what were perceived as unjustifiably high administrative expenses was a driving force in the impetus Canadian legislation gave to a "single-payer" system.

The [Royal] Commissioners<sup>160</sup> concluded that private, for-profit insurers operated under incentives which tended to increase this form of overhead cost,<sup>161</sup> adding to the expense of health care without adding to the resources available to provide it. High retention ratios (low loss ratios) were not an aberrant result of inefficiency, or a transient effect of small scale, but a fundamental characteristic of (successful) private insurance. This inherent tendency is strongly reinforced in a competitive environment with multiple insurers, in which the cost of intensive marketing and of increasingly careful risk selection must also be found out of the retention ratio (footnote omitted). Regarding the costs of the insurance mechanism as unproductive overhead, they recommended centralized, non-profit administration in order to minimize them.<sup>162</sup>

The logic underlying this conclusion is highly suspect, though widely shared.<sup>163</sup> Surely insurance companies have the same marketplace incentive to compete on levels of expense as do other profit-seeking firms. Market reforms short of complete centralization of administration, e.g., required acceptance of any applicant, with the resultant elimination of underwriting expense, and standardized, aggregated marketing, could have addressed concerns about specific types of ex-

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cases clearly below the level of their marginal costs. Alberta formerly employed such limits but has repealed them. *See id.*

<sup>160</sup> *See supra* notes 58–60 and accompanying text.

<sup>161</sup> "Overhead cost" as used here means the amount of premium retained by insurance companies to pay for their expenses and to provide a profit.

<sup>162</sup> EVANS & LAW, *supra* note 56, at 29.

<sup>163</sup> Based on the author's experience as a health care actuary in the large employer market, as recently as ten years ago, large employers in the United States focused almost entirely on insurer retention when considering the cost of their health benefit programs. Insurer pleas that employers ought to be looking at the total cost of their programs fell on unreceptive ears. However, as total cost exploded, the concept that a higher level of expense might reduce total costs became popular. This is, after all, the central assumption of the "managed care" movement. Naturally, not every cost-containment measure proved effective, and some that were initially effective became ineffective over time.

pense, while preserving the competitive incentives to reduce the levels of other expenses.

Evans and Law consider the expense advantage of the Canadian system to be self-evident and substantial.<sup>164</sup> That premise has increasingly come under attack. The basic argument is that:

Any insurer, private or public, must perform three functions: collect premiums, monitor and pay for services (control moral hazard), and bear the risk that is not eliminated by the law of large numbers. In private insurance markets, the cost of performing these functions appears as accounting overhead of premium collection, claims administration, return on capital, and so forth.

The methods used by public insurers to perform these same functions generate lower observable costs but much higher hidden costs.<sup>165</sup>

While these counterattacks are themselves unpersuasive, their failure does not itself prove the superiority with respect to administrative expense of a single-payer system over health care reform like that proposed by the Clinton administration in the United States. As I have argued above, there is sound reason to hope that in such a system, funds devoted to administrative expense would be more cost-effective than in either the current American or Canadian systems.

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<sup>164</sup> See EVANS & LAW, *supra* note 56, at 29–31.

<sup>165</sup> Patricia M. Danzon, *Hidden Overhead Costs: Is Canada's System Really Less Expensive?* 21 HEALTH AFFAIRS 22 (Spring 1992). The article concludes that: "overhead costs in Canada, adjusted to include some of the most significant hidden costs, are indeed higher than they are under private insurance in the United States." *Id.* at 40. This conclusion rests on many dubious assumptions: e.g., the economic losses which result from financing by income taxation, estimated at a minimum of 17%; the costs of controlling overuse of medical resources by excess patient waiting, estimated at between 10 and 110% of physician expenditures and at more than 7% of hospital expenditures. See *id.* at 31–32, 37. An especially glaring omission given the latter argument is any comparison between mean patient waiting times in the United States and Canada. In proprietary insurance company studies to which the author has had access, no argument can be made that levels of expense are comparable without counting as a health care cost a share of the cost of provincial debt service proportionate to health care's share of provincial expenditures. Such treatment of debt would neither be historically accurate nor politically sound. It is clear that electorates as well as individuals are willing to pay for their health care. I do not think it rash to conclude that government-financed health care in Canada would survive a ban on deficit spending.

### O. *Generalizing from the Canadian Experience*

Evans and Law, reflecting on the history of government involvement with health care in Canada, make a series of generalizations which I think both apt and instructive, not only with respect to Canada, but also with respect to considering health care reform in the United States.<sup>166</sup> I give below a summarizing paraphrase:

1. *Things take a long time.* Fifty years elapsed between the first serious discussions of government intervention and the establishment of the last provincial program.

2. *The present tends to be much like the past.* Public funding has the effect of freezing in place the fee-for-service delivery mechanism.

3. *If it is not fixed, it stays broken.* Government intervention left unaddressed and has not corrected patterns of overutilization and physician oversupply.

4. *Giving people things is easier than taking them away.* Provider prerogatives are especially difficult to curtail once granted.<sup>167</sup>

There is, therefore, an implementation dilemma. Acceptance of change is easiest when change is minimal, but minimal change freezes in place existing problems.<sup>168</sup>

#### 1. Future Prospects

Budgetary pressures on the federal and provincial governments are unlikely to abate in the foreseeable future, as evidenced by the enactment of the Canada Health and Social Transfer.<sup>169</sup> The Canadian insistence on an egalitarian, largely government-financed health care system means that these pressures and the cost containment measures they have prompted affect middle- and upper-class consumers and their providers as well as the poor and those who provide the poor with medical services.<sup>170</sup> In the United States, by contrast, politically powerful middle- and upper-class consumers have, so far, been largely insu-

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<sup>166</sup> See EVANS & LAW, *supra* note 56, at 15.

<sup>167</sup> See *id.* While Evans and Law list this point only as an observation, it is exactly what one would expect from an analytic perspective. The interests of providers in provider reimbursement and perquisites is obviously more concentrated than that of any other constituency interested in health care costs. Diffusion of interest among the other constituencies will nearly always mean underinvestment, from the perspective of constituencies as social aggregates, by the individual members of the social aggregates, in defending those interests.

<sup>168</sup> See EVANS & LAW, *supra* note 56, at 15.

<sup>169</sup> See Canada Health and Social Transfer, *supra* note 95.

<sup>170</sup> See Iglehart I, *supra* note 137, at 203.

lated from the effects of government cutbacks by the extent of non-governmental financing and by the open-ended Medicare entitlement.

It is precisely the success that Canada has enjoyed in restraining costs, without compromising health outcomes,<sup>171</sup> that has generated the outrage noted by the *New York Times*,<sup>172</sup> as Dr. Steven Katz so acutely noted in his letter commenting on the *Times*' article.<sup>173</sup> The era when health care costs rose steadily at rates far in excess of rates of growth of the economy as a whole generated expectations among providers and consumers of health care that cannot be met now that that era has ended in Canada.<sup>174</sup>

Even within the constraints imposed by limiting health care spending to a constant percentage of GDP, the structure of the Canadian health care system permits further evolution of the health care delivery system that might increase consumer satisfaction without increasing costs. Although, as noted above, Evans and Law argue that public financing tended to arrest development of provider reimbursement at the fee-for-service stage,<sup>175</sup> I have argued above that the Canada Health Act in fact sanctions a broader array of health care delivery systems.<sup>176</sup>

In particular, an HMO offering open access to a stated number of enrollees, without subscriber co-payments, by agreement with a provincial government, appears not to violate the provisions of the Canada Health Act.<sup>177</sup> The more intensive management of care usual in an HMO should improve the overall efficiency of the Canadian health

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<sup>171</sup> See CANADA'S HEALTH SYSTEM, POLICY AND CONSULTATION BRANCH, HEALTH CANADA 4-5 (Aug. 1996); see also OECD IN FIGURES, supplement to THE OECD OBSERVER, No. 200, 48-51 (June/July 1996).

<sup>172</sup> Steven Jay Katz, M.D., Editorial, *Don't Distort Flaws in Canada Health Care; Painful Price Tag*, N.Y. TIMES, Dec. 22, 1996, at D8.

<sup>173</sup> See *id.*

<sup>174</sup> This is a critical point of another excellent letter criticizing the DePalma article. See Earl Berger, Editorial, *Don't Distort Flaws In Canada Health Care*, N.Y. TIMES, Dec. 22, 1996, at D8. Mr. Berger, managing director of the Canada Health Monitor, also points out that, contrary to the article's claim that increasing numbers have sought medical services in the United States, the percentage of Canadians using services outside their own provinces has remained constant, at 3%, since 1990, and that most of those who did seek services elsewhere did so in other Canadian provinces. See *id.* Further, Berger noted that the proportion of Canadians reporting a wait for specialist services remained constant at 15% between 1990 and 1994, while the percentage reporting long waits actually declined. See *id.*

<sup>175</sup> See EVANS & LAW, *supra* note 56, at 15; see also *supra* notes 164-66 and accompanying text.

<sup>176</sup> See Canada Health Act, ch. 6, 1983-1984 S.C. 273 (Can.); see also *supra* notes 79-91 and accompanying text.

<sup>177</sup> Bruce Davis, Director General, Health Insurance Branch, Health Canada has cautiously endorsed this conclusion in an email to the author (March 13, 1997). He added these qualifications: there should be opportunities for exit, either at periodic times or by formal request; there



care system, and thus its cost-effectiveness. Further, Canadians could no doubt profitably employ many other techniques of "managed care" developed in the United States as a private sector response to escalating health care costs. The very different histories of health care financing in the United States and Canada have given each country an opportunity to learn from the other. That opportunity should not be squandered.

### III. SWITZERLAND<sup>178</sup>

#### A. *History and Government*

Switzerland is a country of four languages, German, French, Italian, and Romansh,<sup>179</sup> and two main religions, Protestant and Catholic.<sup>180</sup> The existence of the Swiss Confederation is anomalous even by the

would have to be provision for out-of-network emergency services; provisions to guard against HMOs targeting favorable risks would also be important.

<sup>178</sup>In response to a request from Michael J. Graetz, Justus S. Hotchkiss Professor of Law, Yale Law School, addressed to the Federal Office of Social Insurance, M. Gross, lic. rer. pol., of the Health Economics Section of the Division of Medicine and Health Economics of the Federal Office of Social Insurance, in May 1994, provided Professor Graetz with extensive materials on the existing state of health insurance law in Switzerland. These materials included a variety of government initiatives aimed at reinforcing the social character of the Swiss system of health insurance and at reducing its costs. Professor Graetz was kind enough to share these materials with me.

In March 1997, in response to a request from the author, Markus Moser, Associate Director of the Health and Accident Division, Federal Office of Social Insurance, provided a substantial corpus of additional material, both primary and secondary. As the many references to the materials received both from Mr. Gross and Mr. Moser below will attest, the information they provided was central to the discussion which follows. Further, I believe that the developments they chronicle are highly relevant to the debate over health care reform in the United States. I am deeply grateful to Professor Graetz, and to the Swiss authorities, especially to Messrs. Gross and Moser, for their invaluable contribution to this article.

<sup>179</sup>See Alfred Maurer, *Switzerland*, in PETER A. KÖHLER, HANS F. ZACHER & MARTIN PARTINGTON, *THE EVOLUTION OF SOCIAL INSURANCE 1881-1981: STUDIES OF GERMANY, FRANCE, GREAT BRITAIN, AUSTRIA AND SWITZERLAND* 384 (1982); GEORG THÜRER, *FREE AND SWISS* 12, 181 (R.P. Heller and E. Long trans., 1972). Romansh, though spoken by only 50,000 Swiss, located principally in the canton of Grisons, is a national language under the Swiss constitution, though not of the same rank as German, French, and Italian, which are official languages. See Maurer, *supra*, at 384; THÜRER, *supra*, at 12, 181.

<sup>180</sup>See Maurer, *supra* note 179, at 384. It seems odd, at least to me and perhaps to most Americans, to speak of Protestantism, firstly as if it were a coherent whole, and secondly as a "religion" different from Catholicism. Americans tend to think of Christianity as a religion and of its subdivisions as "denominations." See, e.g., the definitions of "Christianity," "denomination," "Catholicism" and "Protestantism" in WEBSTER'S NINTH COLLEGIATE DICTIONARY. However much we deplore, quite rightly, what religious and ethnic prejudice exists in the United States, viewed from the European perspective, Americans are, and have always been, remarkably tolerant, as

historical standards of fractious Europe. If Italian speakers to the south and German speakers to the north had achieved political unification before the second half of the nineteenth century, it seems reasonable to suppose that Switzerland would have been divided among Germany, Italy, and France.

Switzerland traces its antecedents as an independent republic to the late Middle Ages, though it attained essentially its existing territorial extent only at the Congress of Vienna in 1815.<sup>181</sup> The federation of the Swiss, despite their linguistic and religious differences, is largely the result of their own free choice, not the result of an association forced by some on others. It was only with the adoption of the Constitution of 1848, however, that Switzerland was transformed from a federation of sovereign states, the cantons, into a confederation where the cantons and the federal government shared the sovereignty of the state.<sup>182</sup>

The current Swiss constitution is that of 1874, which strengthened the powers of the central government.<sup>183</sup> The constitution of Switzerland, however, reserves to the cantons powers not explicitly delegated to the federal government.<sup>184</sup> The Swiss national legislature, the National Assembly, consists of two houses, the National Council, with two hundred members elected nationally on the basis of proportional representation,<sup>185</sup> and the State Council, with two members from each "full" canton and one member from each "half" canton.<sup>186</sup> In joint session, acting as the United National Assembly, the Swiss legislators elect the Federal Council, the executive power of the federal government.<sup>187</sup> The Federal Council has seven members, elected for terms of four years.<sup>188</sup> One of these seven is each year designated Federal President, the Swiss head of government.<sup>189</sup>

The Swiss constitution provides for a remarkable degree of direct democracy through extensive powers of initiative and referendum.<sup>190</sup>

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recent events in Bosnia serve all too sadly to remind us. Indeed, though I have no reason to doubt Swiss tolerance, *see* THÜRER, *supra* note 179, at 11–12, the last Swiss civil war, in 1847, was fought between Catholics and Protestants. *See id.* at 106–10.

<sup>181</sup> *See* THÜRER, *supra* note 179, at 23–34, 94.

<sup>182</sup> *See id.* at 113–14.

<sup>183</sup> *See* BV, CST., COST. FED. [Constitution] (Switz).

<sup>184</sup> *See id.* art. 3; Maurer, *supra* note 179, at 384.

<sup>185</sup> *See* THÜRER, *supra* note 179, at 166.

<sup>186</sup> *See* Maurer, *supra* note 179, at 385.

<sup>187</sup> *See id.*

<sup>188</sup> *See id.*

<sup>189</sup> *See id.*

<sup>190</sup> *See id.*

One hundred thousand signatures suffice to submit a proposal for constitutional revision to a national plebiscite.<sup>191</sup> Approval requires majorities both of the popular vote and of the outcomes by canton.<sup>192</sup>

Federal laws and certain other decrees which the National Council and the State Council have approved are subject to facultative referendum. They must be submitted to the people for acceptance or rejection, if this is requested at the time by 50,000 voters. Only [a] majority of the [popular vote] . . . is decisive; a majority of the cantons . . . is not needed.<sup>193</sup>

There is no statutory power of initiative, which has resulted in inclusion in the constitution of changes more appropriate to statutory revision.<sup>194</sup>

One of the seven federal councilors is head of the Department of the Interior, which is responsible for most social insurance programs.<sup>195</sup> One of its divisions, the Federal Office for Social Insurance, supervises social insurance programs, drafts new social insurance legislation, and is the court of appeal for the adjudication of certain complaints.<sup>196</sup>

The United National Assembly also elects the Federal Insurance Court in Lucerne.<sup>197</sup>

This acts as the federal court for social insurance as it represents the supreme judicial authority in the field of Swiss social insurance. While it was originally completely separate from the Federal Law Court, the legislature made the Insurance Court part of the Federal Law Court, although its organization has remained entirely independent, with an amendment of 20 December 1968 to the Federal Law on the Organization of Federal Administration of Justice. . . . The judges are elected separately by the National Assembly.<sup>198</sup>

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<sup>191</sup> See Maurer, *supra* note 179, at 385.

<sup>192</sup> See *id.*

<sup>193</sup> See *id.*

<sup>194</sup> See *id.* at 386.

<sup>195</sup> See *id.* at 385.

<sup>196</sup> See Maurer, *supra* note 179, at 385.

<sup>197</sup> See *id.*

<sup>198</sup> *Id.*

## B. Health Insurance

Article 34 of the Constitution of 1874, still in force, authorized the federal government to regulate the employment of children and the working hours of adults in factories, and to protect workers against industrial accidents.<sup>199</sup> With this foundation, the National Assembly in 1877, passed the Federal Law on Work in Factories, which survived a referendum challenge by 10,347 votes out of 352,061 cast.<sup>200</sup> Following the example of the canton of Glarus, the Factory Act mandated a maximum work day of eleven hours, provided sixteen weeks of maternity leave, raised the minimum age for child labor to fourteen, and required that time for schooling be subtracted from the eleven hour maximum for children aged fourteen to sixteen.<sup>201</sup> It authorized enforcement by government inspectors.<sup>202</sup> It also established broad, but not universal, employer liability for workplace accidents.<sup>203</sup>

Building on experience with application of the workplace accident liability provisions, and inspired by the pioneering German legislation on workers' compensation, the National Assembly proposed the following amendment to the Swiss constitution:

In the course of legislation the federal government will establish sickness and accident insurance, taking existing sickness insurance into account. It can declare that membership is either universally compulsory or only compulsory for individual sections of the community.<sup>204</sup>

The amendment was adopted by a margin of over three to one, providing the federal government for the first time with both a constitutional foundation and a popular mandate for social insurance legislation.<sup>205</sup>

After study of the German and Austrian health and accident insurance systems, the National Assembly enacted in 1899 a system of health

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<sup>199</sup> See *id.* at 396.

<sup>200</sup> See *id.* at 400.

<sup>201</sup> See Maurer, *supra* note 179, at 400–01.

<sup>202</sup> See *id.*

<sup>203</sup> See *id.* The Factory Liability Law of 25 June 1881, confirmed the broad principles of employer liability, but restricted somewhat their application by establishing maximum awards regardless of damages and by urging consideration of employer solvency when making an award. See *id.* at 401.

<sup>204</sup> *Id.* at 410.

<sup>205</sup> See Maurer, *supra* note 179, at 410.

and accident insurance compulsory for all employed persons over the age of fourteen with annual incomes less than 5,000 francs.<sup>206</sup> Despite endorsement by all political parties, the legislation was resoundingly rejected in a referendum on May 20, 1900, after opposition by the insurance industry: "The bill was said to represent the 'beginning of state Socialism' and was considered to be 'centralistic.'"<sup>207</sup>

Proponents of social insurance were slow to regroup after so decisive a rebuff. The eventual revision proposed uncoupling health insurance from workers' compensation, providing only subsidies for private health insurance which met certain criteria while enacting once again a compulsory, state system of workers' compensation.<sup>208</sup> The health insurance proposal did expand upon its foreign exemplars in one respect, however, in that it subsidized coverage for all Swiss citizens, not merely for employed persons.<sup>209</sup> By a margin of 287,656 for to 241,426 against, The Federal Law on Sickness and Accident Insurance of 13 June 1911 withstood a referendum challenge.<sup>210</sup>

### C. *Health Insurance Provisions of 13 June 1911 Act, as Effective Until 31 December 1995*

The Health Insurance Provisions of 13 June 1911 Act promoted health insurance by granting premium subsidies to insureds enrolled in health insurance funds which the Federal Council had determined met the Act's requirements.<sup>211</sup> The individual cantons had the right to make health insurance mandatory either for the population at large or for defined classes, and to create public insurance plans. The cantons were permitted to require employers to assure that employees subject to compulsory enrollment in plans paid their premiums, presumably through payroll deduction, but were prohibited from requiring that the employers themselves contribute to the cost of the coverage.<sup>212</sup>

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<sup>206</sup> *See id.* at 410–11.

<sup>207</sup> *Id.* The analogies to insurance company opposition to the 1994 proposal of the Clinton administration for reform of health care financing in the United States are uncanny. *See* H.R. 3600, 103d Cong. (1993); S. 1757, 103d Cong. (1993). Closer attention to relevant foreign experience might have better prepared the Clinton administration to make its case with the public.

<sup>208</sup> *See* Maurer, *supra* note 179, at 412.

<sup>209</sup> *See id.*

<sup>210</sup> *See id.*

<sup>211</sup> LOI FÉDÉRALE SUR L'ASSURANCE EN CAS DE MALADIE ET D'ACCIDENTS DU 13 JUIN 1911, RS 832.10, art. 1 (Berne 1912) [hereinafter 13 JUNE 1911 ACT].

<sup>212</sup> *See id.* art. 2.

Eligible organizations had to be adequately capitalized insurance companies, resident in Switzerland, conducting at least their health insurance business as mutual companies.<sup>213</sup> The articles of incorporation could limit enrollment to members of particular occupations, religions or political parties,<sup>214</sup> but the right actually to discriminate on these bases was sharply curtailed. While Article 5 stated that no plan could refuse enrollment on the basis of religion or membership in a political party to an applicant who does not meet the requirements of any other plan operating in his/her place of residence, Article 11 appeared to make Article 5 superfluous, since it prohibited plans from excluding anyone for religious or political reasons.<sup>215</sup> Article 6 prohibits discrimination on the basis of sex.<sup>216</sup>

#### D. *Portability*

Eligible plans had to assure portability of coverage from one plan to another with similar enrollment requirements.<sup>217</sup> Additionally, these plans could not impose either age, pre-existing conditions or transfer fee requirements on a previously enrolled person who wished to transfer coverage.<sup>218</sup> A transferee had to receive coverage at the same price as an enrollee of his/her same attained age.<sup>219</sup>

#### E. *Minimum Benefits*

Plans had to provide their members with health care, including drugs, or with a minimum total disability benefit of one Swiss franc per day.<sup>220</sup> The maximum probationary period for eligibility for a disability benefit was three months.<sup>221</sup> Health care benefits had to be paid from the beginning of a qualifying illness, and a disability benefit no later than from the third day after the beginning of the disability.<sup>222</sup> The maximum annual disability benefit could be no less than 180 days.<sup>223</sup>

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<sup>213</sup> See *id.* art. 3, § 3.

<sup>214</sup> See *id.* art. 3. Further, Article 28 prohibits the use of insurer capital in non-insurance ventures. See *id.* art. 28.

<sup>215</sup> See *id.* arts. 5, 11.

<sup>216</sup> See 13 JUNE 1911 ACT, *supra* note 211, art. 6.

<sup>217</sup> See *id.* arts. 7–10.

<sup>218</sup> See *id.*

<sup>219</sup> See *id.*

<sup>220</sup> See *id.* art. 12.

<sup>221</sup> See 13 JUNE 1911 ACT, *supra* note 211, art. 13.

<sup>222</sup> See *id.*

<sup>223</sup> See *id.*

Plans could require a 25% copayment toward health care costs if their maximum benefit period was at least 266 days per year.<sup>224</sup>

Pregnancy had to be treated as equivalent to an illness if the insured had been a member for at least nine months.<sup>225</sup> A disability benefit for pregnancy had to last at least six weeks, though if the insured continued to work, her wages could offset the benefit.<sup>226</sup> Mothers still nursing four weeks after the expiration of their disability benefit were entitled to an additional payment of at least 20 francs.<sup>227</sup>

#### F. *Choice of Physicians*

Article 15 guaranteed an insured a choice among the physicians practicing in his or her area.<sup>228</sup> Plans could limit that right if they were able to negotiate fee arrangements with physicians. Any physician practicing in the plan's area for at least a year had to be free to join the "network" if he or she was willing to accept the negotiated fees.<sup>229</sup> The fees had to be the same for every member of a plan.<sup>230</sup> If plans were unable to negotiate fees, they could substitute for up to a year a reimbursement set by the cantonal government at the average medical fee.

If hospitalization was required, the plans were free to entrust the care of their insureds to the hospital's staff.<sup>231</sup> The plans could employ "physician reviewers" to oversee the medical care of their insureds,<sup>232</sup> and were not required to pay either for medically unnecessary treatment or for unprescribed drugs.<sup>233</sup> The Act prohibited over-insurance.<sup>234</sup>

#### G. *Pharmaceuticals*

Article 19 established rules for pharmacists corresponding to those of Articles 15–17 for physicians.<sup>235</sup>

<sup>224</sup> *See id.*

<sup>225</sup> *See id.* art. 14.

<sup>226</sup> *See* 13 JUNE 1911 ACT, *supra* note 211, art. 14.

<sup>227</sup> *See id.*

<sup>228</sup> *See id.* art. 15.

<sup>229</sup> *See id.* art. 16.

<sup>230</sup> *See id.* art. 23.

<sup>231</sup> *See* 13 JUNE 1911 ACT, *supra* note 211, art. 17.

<sup>232</sup> *See id.* art. 18.

<sup>233</sup> *See id.* art. 23.

<sup>234</sup> *See id.* art. 26.

<sup>235</sup> *See id.* arts. 19, 15–17.

## H. *Health Care Charges*

After consultation with health insurance plans and medical and pharmacists' associations, cantonal governments had the responsibility of setting the range of allowable fees for all medical services and pharmaceuticals.<sup>236</sup> In setting these rates, the Act mandated that the cantonal authorities consider local circumstances and the rates the health plans had been able to negotiate.<sup>237</sup> Negotiated rates had to conform to the cantonal fee schedule.<sup>238</sup>

## I. *Disputes Between Providers and Plans*

Article 25 stated that cantonal governments would develop both an arbitration mechanism and procedures.<sup>239</sup> The arbitration procedures had to accord equal representation to the disputing parties.<sup>240</sup> The arbitration authorities resolved disputes between plans and providers, including a disagreement over a plan's decision to disqualify a provider for reasons of personal or professional misconduct from providing services to its members.<sup>241</sup>

## J. *Other Provisions Affecting the Status of Plans*

Private law disputes among plans, between plans and their members, or between plans and third persons, were subject to the normal legal process, unless cantonal law or provisions of plan governance provided otherwise.<sup>242</sup> Plans were exempt from taxes, except those on capital not deployed in the business of insurance.<sup>243</sup> Plans had annually to compute and report to the Federal Council the results of their operations.<sup>244</sup> The Federal Council could assess penalties against plans not complying with the Act, including withdrawal of plan qualification as a last resort.<sup>245</sup> Plans could voluntarily renounce their qualification.<sup>246</sup>

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<sup>236</sup> See 13 JUNE 1911 ACT, *supra* note 211, art. 22.

<sup>237</sup> See *id.*

<sup>238</sup> See *id.*

<sup>239</sup> See *id.* art. 25.

<sup>240</sup> See *id.*

<sup>241</sup> See 13 JUNE 1911 ACT, *supra* note 211, art. 24.

<sup>242</sup> See *id.* art. 30.

<sup>243</sup> See *id.* art. 31.

<sup>244</sup> See *id.* art. 32.

<sup>245</sup> See *id.* art. 33.

<sup>246</sup> See 13 JUNE 1911 ACT, *supra* note 211, art. 34.



### K. *Subsidies*

For health care policies with no disability benefit, or for those with only a disability benefit of at least one franc a day, the Act provided a premium subsidy of 3.5 francs for children under fourteen and adult men and 4 francs for adult women.<sup>247</sup> If a policy provided both benefits, it received a subsidy of 5 francs.<sup>248</sup> The subsidies were increased by one-half franc for plans which provided health care benefits for 360 days in a period of 540 consecutive days.<sup>249</sup> The federal government provided an additional subsidy of 20 francs for each pregnancy, increased to 40 francs if the mother qualified for the additional nursing benefit.<sup>250</sup> Federal subsidies could not exceed half the total income of a plan, and only a single subsidy was payable per individual.<sup>251</sup>

Additional subsidies were provided to assist cantonal and local governments in providing health care in thinly populated, medically underserved areas.<sup>252</sup> If cantonal or local governments made health insurance obligatory, in general or for particular classes of the population, and if they subsidized the cost of coverage for the poor, the federal government matched one-third of their expenditures.<sup>253</sup>

In an illustration of permitted differences in premiums, Kurt Krumbiegel hypothesizes a premium of eight tenths of a franc per month for the minimum permitted disability benefit of one franc per day.<sup>254</sup> If the example is realistic, which seems plausible in light of the restriction on subsidies in Article 36, the subsidy for a minimum benefit plan was nearly 40% of its total cost.<sup>255</sup> If a cantonal government required health insurance coverage, and subsidized 100% for the poor the individual contribution otherwise required, the operation of Article 38 would have raised the level of federal subsidy to 60% ( $40\% + 1/3(100\% - 40\%) = 60\%$ ).<sup>256</sup>

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<sup>247</sup> See *id.* art. 36.

<sup>248</sup> See *id.*

<sup>249</sup> See *id.* This compares to the minimum benefit of 180 days out of 360 days. See *id.*

<sup>250</sup> See *supra* note 226 and accompanying text.

<sup>251</sup> See 13 JUNE 1911 ACT, *supra* note 211, art. 36.

<sup>252</sup> See *id.* art. 37.

<sup>253</sup> See *id.* art. 38.

<sup>254</sup> KURT KRUMBIEGEL, DIE SCHWEIZERISCHE SOZIALVERSICHERUNG 14 (1913).

<sup>255</sup> See *id.*

<sup>256</sup> See *id.*

L. *Amendment of 13 March 1964*<sup>257</sup>

The only major amendment of the 1911 Act prior to its replacement in 1994 occurred in 1964.<sup>258</sup> The amendment adapted the principles of the earlier law to the realities of modern insurance and medical cost inflation, but left unchanged its basic principles.<sup>259</sup> Article 5, new Sections 3 and 4 prohibited the funds from refusing to accept a member for reasons of ill health or pregnancy.<sup>260</sup> However, the funds could enforce pre-existing conditions restrictions for at most five years after enrollment.<sup>261</sup> A new Article 5, Part II recognized the eligibility of group insurance programs for subsidy.<sup>262</sup> Persons insured under a group contract had to have the right to convert to an individual policy if their eligibility for group insurance ended.<sup>263</sup>

Health insurance premiums could vary by enrollment age, sex,<sup>264</sup> area, and, as permitted by regulation, family status.<sup>265</sup> Article 12, Part II spelled out with somewhat greater specificity the health care benefits required, though they remained very general.<sup>266</sup> The principle change was that hospital and disability (and health spa!) benefits had to last for at least 720 out of 900 consecutive days.<sup>267</sup> Benefits for confinement in a tuberculosis sanatorium had to be available for 1800 days out of seven consecutive years.<sup>268</sup> Pregnancy had to be treated as the equivalent of an illness, if the insured had been a fund member for at least 270 days without an interruption of more than three months.<sup>269</sup> Midwifery and pre-natal and post-natal care had to be included as ben-

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<sup>257</sup> Amendment to 13 JUNE 1911 ACT, *supra* note 211, LOI FÉDÉRALE DU 13 MARS 1964 MODIFIANT LE PREMIER TITRE DE LA LOI SUR L'ASSURANCE EN CAS DE MALADIE ET D'ACCIDENTS, RO 1964 965 [hereinafter 1964 Amendment].

<sup>258</sup> *See id.*

<sup>259</sup> *See id.*

<sup>260</sup> *See id.* art. 5, §§ 3, 4.

<sup>261</sup> *See id.*

<sup>262</sup> *See* 1964 Amendment, *supra* note 257, art. 5, pt. II.

<sup>263</sup> *See id.*

<sup>264</sup> However, cash sickness pay premiums cannot vary by sex. *See* 13 JUNE 1911 ACT, *supra* note 211, art. 5, amended by 1964 Amendment, *supra* note 257, art. 12, pt. II.

<sup>265</sup> *See id.* art. 6, pt. II.

<sup>266</sup> *See id.* art. 12, pt. II.

<sup>267</sup> *See id.* pt. III.

<sup>268</sup> *See id.*

<sup>269</sup> *See* 13 JUNE 1911 ACT, *supra* note 211, amended by 1964 Amendment, *supra* note 257, art. 14.

efits.<sup>270</sup> Home delivery had to be an option for the insured.<sup>271</sup> The nursing benefit was increased to 50 francs.<sup>272</sup>

The funds were permitted to impose deductibles and copayments, which could not vary by sex and which could not be higher in cases of hospitalization, tuberculosis, spa cures or pregnancy.<sup>273</sup> The funds were permitted to charge a fee for providing copies of medical records.<sup>274</sup> The expected value of the deductible could not exceed a tenth of the cost of the health care coverage provided.<sup>275</sup>

Article 19, Part II extended mandatory freedom of choice on the part of the insured to hospitals.<sup>276</sup> If the insured chose a hospital with which the fund did not have a provider contract, however, the fund's payment could be limited to the rate at the hospital nearest the residence of the insured with which it did have a contract.<sup>277</sup> Freedom of choice extended also to approved tuberculosis sanitoriums and health spas.<sup>278</sup>

In addition, Article 21, Sections 4 through 6 imposed on the funds the requirement of paying for chiropractors, midwives and other health care professionals practicing within the scope of their licenses.<sup>279</sup>

Article 22 permitted the funds to vary the rate of payment to physicians by the economic status of the insured.<sup>280</sup> Where payment rates varied, the premium rates had to vary as well.<sup>281</sup> The Amendment provided a more specific framework for the fixing of fees than formerly existed, which in theory gave the cantonal authorities a significant role.<sup>282</sup> Article 23 restricted practitioners to medical treatment in the interests of the insured which are necessary and medically recog-

<sup>270</sup> *See id.*

<sup>271</sup> *See id.*

<sup>272</sup> *See id.*

<sup>273</sup> *See id.* pt. II.

<sup>274</sup> *See* 13 JUNE 1911 ACT, *supra* note 211, amended by 1964 Amendment, *supra* note 257, art. 14, pt. II.

<sup>275</sup> *See id.*

<sup>276</sup> *See id.* art. 19, pt. II.

<sup>277</sup> *See id.*

<sup>278</sup> *See id.*

<sup>279</sup> *See* 13 JUNE 1911 ACT, *supra* note 211, amended by 1964 Amendment, *supra* note 257, art. 21, §§ 4-6.

<sup>280</sup> *See id.* art. 22.

<sup>281</sup> *See id.* I suppose, without certainty, that this reflects existing cantonal programs for providing care to the indigent.

<sup>282</sup> *See* 13 JUNE 1911 ACT, *supra* note 211, amended by 1964 Amendment, *supra* note 257, pts. II-V, art. 73, pt. II.

nized.<sup>283</sup> Amendment of Article 35 revised the calculation of the federal subsidy.<sup>284</sup> The basic rates of contribution were 10% for adult men, 35% for adult women, and 30% for children fifteen years of age and under. There were additional subsidies for pregnancy and tuberculosis.<sup>285</sup> In a report as recent as February of 1994, the Swiss Office of Social Insurance described the law of 1911, as revised in 1964, as essentially the law still in force.<sup>286</sup> Despite a plethora of proposals, the degree of consensus necessary for reform given the nature of Swiss government had not yet materialized.<sup>287</sup>

### M. *Subsequent Piecemeal Reforms*

The relentless increase in medical costs, which has been more pronounced in Switzerland than anywhere else in Europe, led to a series of temporary palliatives while the Swiss struggled to find the high level of consensus needed for fundamental reform. For example, in 1990, the Federal Council raised the standard deductible to 150 francs,<sup>288</sup> and in 1992 extended the application of deductibles and daily copayments (in the place of co-insurance) to hospitalization.<sup>289</sup> Earlier, in 1986, the Federal Council had permitted insurers to offer optional higher deductibles in exchange for lower premiums.<sup>290</sup>

<sup>283</sup> I equate this to be the ban in the United States on experimental treatment. See 13 JUNE 1911 ACT, *supra* note 211, amended by 1964 Amendment, *supra* note 257, art. 23.

<sup>284</sup> See *id.* art. 35.

<sup>285</sup> See *id.* arts. 36, 37.

<sup>286</sup> Swiss Reform, *supra* note 73.

<sup>287</sup> *Id.* In 1974, the popular and cantonal votes rejected both a popular initiative and a counter-proposal by the federal government. See *supra* notes 182–88 and accompanying text. The initiative would have made health insurance obligatory and created a subsidized disability insurance. See Swiss Reform, *supra* note 73, at 6. The Federal Council's counter-proposal would have made emergency coverage and disability insurance for workers obligatory. See *id.* However, Parliament proposed a quite different program, which would have maintained a wholly voluntary system of participation while introducing compulsory contributions for health insurance. See *id.* It would have also made disability insurance mandatory for workers. See *id.*

In 1987, the voters rejected a proposal that abandoned compulsory disability insurance for workers and that would merely have mandated a maternity benefit. See *id.* at 6.

<sup>288</sup> See Ordonnance V sur l'assurance-maladie concernant la reconnaissance des caisse-maladies et des fédérations de réassurance, ainsi que leur sécurité financière, du 2 février 1965 (as amended) [hereinafter Ordonnance V] in ASSURANCE-MALADIE/ LOI FÉDÉRALE/ ARRÊTÉS FÉDÉRAUX/ DISPOSITIONS D'EXÉCUTION/ INDEX ALPHABÉTIQUE, ÉTAT AU 1ER JANVIER 1994, OFFICE FÉDÉRAL DES ASSURANCES SOCIALES 95, 106 (1994) [hereinafter SWISS HEALTH INSURANCE].

<sup>289</sup> See *id.*; Arrêté fédéral sur des mesures temporaires contre le renchérissement de l'assurance-maladie, du 9 octobre 1992, in SWISS HEALTH INSURANCE, *supra* note 288, at 48–49.

<sup>290</sup> See SWISS HEALTH INSURANCE, *supra* note 288, at 106.

In 1989, the Federal Council authorized a six-year experiment with HMOs.<sup>291</sup> Permitting restrictions on provider choice was a radical departure for the Swiss, who, as we have seen, enshrined freedom of provider choice in their health care financing legislation.<sup>292</sup> The clear purpose of this experiment was to explore the possibility that management of health care delivery would reduce the demand for health care services.<sup>293</sup> The same measure permitted insurers to reduce premiums, from an initially higher base, for insureds who filed no claims throughout the course of a calendar year.<sup>294</sup>

#### N. *Protecting Stability and Maintaining Social Solidarity*

The Swiss adopted several measures which identified protecting "solidarity" as their primary objective.<sup>295</sup> For example, a December 13, 1991, decree of the Swiss Federal Assembly has the title "Federal Decree on Temporary Measures to Protect Solidarity [contre la désolidarisation] in Health Insurance."<sup>296</sup> This decree enacted inter-fund subsidies, transferring money from funds with lower than average enrollments of women and the aged to funds with higher than average enrollments of members of these groups.<sup>297</sup> This measure indeed crossed an important line between a program of subsidy for voluntary insurance and a true program of social insurance.

Such a measure appears to have been the minimum necessary to maintain coverage of the population at high levels. Otherwise, funds that succeeded in enrolling healthier than average segments of the community could assure them lower premiums, while those excluded, whether by marketing tactics or otherwise, might gradually find that they could no longer afford the cost of their higher-priced coverage. In the language of American insurers, this phenomenon is called the "anti-selection death spiral."

<sup>291</sup> See Swiss Reform, *supra* note 73, at 22.

<sup>292</sup> See *supra* note 227 and accompanying text.

<sup>293</sup> See Swiss Reform, *supra* note 73, at 22.

<sup>294</sup> See *id.* at 23. This is a reform of dubious soundness. It has the effect of discouraging the use of low-cost preventive care and of early diagnosis, and that, in terms of overall cost-effectiveness, creates perverse incentives.

<sup>295</sup> See, e.g., SWISS HEALTH INSURANCE, *supra* note 288, at 46.

<sup>296</sup> See *id.* All translations from the French of the original are my own. I have chosen to render "contre la désolidarisation" "protect solidarity" rather than to attempt to make good English out of the word "désolidarisation."

<sup>297</sup> See SWISS HEALTH INSURANCE, *supra* note 288, at 46.

Another important step in the direction of a true social insurance program taken by the decree was the promotion of income-related cantonal subsidies.<sup>298</sup> The decree made available an additional 100 million francs to cantons which reduced health insurance premiums according to the economic need of their inhabitants.<sup>299</sup> In a November 13, 1991, modification to the regulation governing group health insurance promulgated in 1964, the Federal Council established a minimum premium for group health insurance.<sup>300</sup> This minimum was set at the weighted average premium for individually insured persons in the working adult category, less twenty-five percent.<sup>301</sup> This action had the effect of subsidizing individual insureds at the expense of group insureds.<sup>302</sup>

In modifications made December 3, 1990, to premium rating regulations, the Swiss Federal Council limited premiums for the highest age group to double those for working-age adults.<sup>303</sup> This subsidy from young to old also strengthened the social insurance character of the Swiss system. Finally, as part of a decree generally directed against price inflation, the federal government prohibited premium differences by sex.<sup>304</sup> This also strengthened the social insurance character of the system, since it constituted a subsidy from men to women.

### O. Price Controls

The Swiss deservedly have the reputation of being capitalists *par excellence*. The repeated rejection in referenda,<sup>305</sup> prior to that held December 4, 1994, by the Swiss electorate even of modest efforts by the federal government to increase the role of government in managing health care financing itself testifies to the deep Swiss attachment to free markets. Yet, as will be addressed below, the crisis precipitated

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<sup>298</sup> See *id.* at 46–47.

<sup>299</sup> See *id.* In order to qualify, the cantons also had to match the federal contribution, in ratios ranging from three to one to one to one, depending on their individual financial situations.

<sup>300</sup> See Ordonnance II sur l'assurance-maladie du 22 décembre 1964 concernant l'assurance collective pratiquée par les caisses-maladie reconnues par la Confédération, art. 13a [hereinafter Ordonnance II], in SWISS HEALTH INSURANCE, *supra* note 288, at 75.

<sup>301</sup> See *id.*

<sup>302</sup> See *id.*

<sup>303</sup> See *id.* § 3bis; Ordonnance V, art. 17, § 2, in SWISS HEALTH INSURANCE, *supra* note 288, at 101.

<sup>304</sup> See Arrêté fédéral sur des mesures temporaires contre le renchérissement de l'assurance-maladie, art. 4, in SWISS HEALTH INSURANCE, *supra* note 288, at 49.

<sup>305</sup> See *id.*

by rising health care costs led even the Swiss to one of the most extreme forms of government intervention, price controls.

As a first, rather mild, step, as part of the decree discussed above aimed generally at intra-system stability,<sup>306</sup> the government reduced federal subsidies for funds for which the rate of increase in overhead costs exceeded the rate of increase in input costs.<sup>307</sup> The "Federal Decree on Temporary Measures against Health Insurance Price Inflation"<sup>308</sup> froze rates for ambulatory care for 1993, at the levels which existed on June 30, 1992. Rates for pharmaceuticals were frozen at the level which existed on September 15, 1992.<sup>309</sup> The decree permitted an increase in rates for 1994 if the increase in total costs<sup>310</sup> of treatment per insured did not exceed the rate of increase in the Swiss Consumer Price Index by more than one-third. Article 2 of the Decree limited increases in hospital costs to the rates of inflation in the general economy to which they corresponded.<sup>311</sup> Charges for increases in labor costs were limited to the rate of increase in national wages, and for other costs to the rate of increase in the Consumer Price Index.<sup>312</sup>

In addition to an attempt to control input costs, Articles 5 and 6 of the decree imposed direct controls on premium rates themselves.<sup>313</sup> A ceiling was imposed on premium rates.<sup>314</sup> The ceiling, calculated by canton, was equal to the average premium for working adults for the preceding year increased by the rate of increase in the Consumer Price Index multiplied by 1.8.<sup>315</sup>

<sup>306</sup> See *supra* notes 294–96 and accompanying text; Federal Decree on Temporary Measures to Protect Solidarity in Health Insurance of 13 December 1991, in SWISS HEALTH INSURANCE, *supra* note 288, at 46.

<sup>307</sup> See *id.* art 2.

<sup>308</sup> See SWISS HEALTH INSURANCE, *supra* note 288 at 48.

<sup>309</sup> See *id.* at 48. Article 1, Section 2 permitted modest increases in cases where cost increases from 1990 to 1992, had been relatively low. See *id.*

<sup>310</sup> Since the total cost per insured for a category of medical service is the product of the average number of services in the category per insured and the average price per service, this requirement had the effect of constraining prices not only for price inflation, but for utilization increases as well.

<sup>311</sup> See SWISS HEALTH INSURANCE, *supra* note 288, at 49.

<sup>312</sup> See *id.*

<sup>313</sup> See *id.* at 16.

<sup>314</sup> See *id.*

<sup>315</sup> See *id.* at 49–50. For example, if the overall increase in the CPI was 3.0%, the premium would be permitted to increase by 5.4% (3.0% x 1.8 equals 5.4%).

### P. *Percentage of Persons Insured*

This system of incentives and voluntary insurance provided coverage for 96% of the Swiss population.<sup>316</sup> Additionally, 2% of the Swiss population had insurance which did not qualify for the federal subsidy.<sup>317</sup> Only 2% of the population were uninsured.<sup>318</sup>

### Q. *Fundamental Reform*

The important measures just discussed, aiming at promoting social solidarity (or system stability, depending on one's perspective) and combating health care cost inflation, were intended to be temporary, in order to give the government breathing room to develop a fundamental reform of the Swiss health care financing system.<sup>319</sup> On March 18, 1994, the National Assembly repealed the basic law of June 13, 1911, and enacted a new system of social health insurance in its place.<sup>320</sup> The law defines social health insurance to consist of compulsory medical benefits insurance and voluntary disability income insurance.<sup>321</sup> The entry into effect of the legislation was dependent on its approval by the voters in a referendum,<sup>322</sup> which took place on December 4, 1994. By the very narrow margin of 51.8% to 48.2%,<sup>323</sup> the Swiss electorate finally approved major modifications to the health care financing system. The law provides Federal subsidies to the cantons for medical benefits, but not for disability income.<sup>324</sup> Most significant politically, the Swiss statute, "Loi fédérale sur l'assurance-maladie" (hereinafter LAMa1), requires that the cantons use Federal subsidies only to

<sup>316</sup> See SWISS HEALTH INSURANCE, *supra* note 288, at 500, tbl. A.1.

<sup>317</sup> See *id.*

<sup>318</sup> See *id.*

<sup>319</sup> See Swiss Reform, *supra* note 73, at 24.

<sup>320</sup> See Loi fédérale sur l'assurance-maladie (LAMa1) du 18 mars 1994, (Etat le 1er juillet 1995) *in* ASSURANCE MALADIE, OFFICE FÉDÉRAL DES IMPRIMÉS ET DU MATÉRIEL (Bern 1996) [hereinafter LAMa1].

<sup>321</sup> See *id.* art. 1, § 1. The basic scope of the new legislation resembles that of the initiative rejected in 1974. See *supra* note 286.

<sup>322</sup> See LAMa1, *supra* note 320, art. 107.

<sup>323</sup> Fax from the Swiss Embassy to the author received June 27, 1995.

<sup>324</sup> See LAMa1, *supra* note 320, arts. 60 § 1, 65, 66 § 1, 75 § 1, 106 §§ 1, 2. Although LAMa1 Article 60, Section 1, discussing medical benefits insurance, and LAMa1 Article 75, Section 1, discussing disability income insurance, use the same language to describe their financing as a system of sharing of expenses, Article 66 in the medical benefits section of the Act (Title 2) explicitly provides for federal and cantonal subsidies. Article 65 states that these subsidies are used to reduce premiums for the economically disadvantaged. Article 106, Section 1 sets the level



subsidize premiums for the poor.<sup>325</sup> LAMal repealed a major middle class entitlement, a remarkable achievement with unfortunately predictable political results.<sup>326</sup>

We are interested principally in the medical benefits component of social health insurance. Though, as one would expect, the new system has substantial continuity with the old one, it places a far greater emphasis on cost containment and is in fact, as it describes itself in name,<sup>327</sup> a program of social insurance instead of a program of government subsidies to private, voluntary insurance. The greatest conceptual difference is that medical insurance is compulsory. Anyone born or taking up residence in Switzerland must acquire health insurance within three months of birth or of taking up domicile in Switzerland.<sup>328</sup>

In making the case for a movement from a voluntary to a compulsory system, the Swiss authorities accurately (and astutely!) stressed that required participation is a necessary complement to other measures intended to strengthen the social character of Swiss health insurance.<sup>329</sup>

Since the law project had as its objective to eliminate the flaws of the existing system, the principal component of the project is to reinforce social solidarity. While the project continues per capita premiums regardless of the financial position of the insured, it prohibits maximum ages of entry, supplemental morbidity reserves, premium differences by sex or age of entry as well as special premiums for group insurance contracts. Certain measures are intended to reduce premium differences [among insurance carriers]: insureds' complete freedom of choice of carriers (each insured must have the right freely to choose his initial carrier and then to change carriers), as well as risk adjustment among carriers for a period of ten years, [means] that the risk characteristics of a carrier's insured population will not play a major role in

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of federal subsidies for the first four years the new law is in effect. Article 106, Section 2 sets the level of the required matching cantonal matching contribution for those years. There is no provision for subsidies for the voluntary disability income insurance.

<sup>325</sup> See *id.* art. 66.

<sup>326</sup> See *infra* notes 398–401 and accompanying text.

<sup>327</sup> See LAMal, *supra* note 320, art. 1. LAMal Article 1 states: "This law regulates social health insurance. [Social health insurance] includes obligatory medical insurance and optional disability insurance." *Id.*

<sup>328</sup> See *id.* art. 3, § 1. Article 92 makes avoidance of the insurance mandate by misrepresentation a crime punishable by a fine or up to six months imprisonment. See *id.* art. 92.

<sup>329</sup> See Swiss Reform, *supra* note 73, at 29.

determining premiums. *These measures aimed at reinforcing solidarity make compulsory insurance necessary.* In effect, complete freedom of choice of carriers can only be achieved within a structure of mandatory insurance, since supplementary morbidity reserves and premium rating by age are necessary elements of a system of voluntary insurance. The introduction of mandatory insurance is thus [only] a means of achieving the unchanged objective, which is to assure [social] solidarity.<sup>330</sup>

### R. Premium Rating

Given the high degree of participation in the voluntary program, the greatest practical difference is that the new law sharply curtails premium rating. Article 61 permits insurers to vary premiums only by area, with a maximum of three area rates per canton.<sup>331</sup> Insurers must charge a lower rate for children aged 18 or less, which they may extend to age 25 for students.<sup>332</sup> Otherwise, premiums must be equal for all insureds,<sup>333</sup> and premium rates must be approved by the Federal Council.<sup>334</sup>

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<sup>330</sup> *Id.* (emphasis added). Advocates of American health care reform including universal coverage could be excused for wishing that the Swiss Office of Social Insurance had managed the campaign on its behalf instead of the Clinton administration. American advocates of universal coverage have been slow to point out that without it insurance market reforms simply cannot work, as the quotation cited quite rightly insists. *See id.* at 29. If participation is voluntary, the choice whether or not to participate is open to anti-selection, on the grounds of health status if nothing else. However, it is almost certain that any package of reforms that could pass Congress would prohibit premium rating by sex. This creates a considerable additional incentive for males of every age not to participate. For example, health care costs for females under 30 years of age are three times higher than for males within this same age group. An age-, but not sex-, specific premium would cost a male under thirty years of age more than twice his expected medical costs. Telephone Interview with John Bohon, Actuary, Aetna US Healthcare, Blue Bell, Pennsylvania (February 12, 1998) (citing statistics based on more than one million member months of HMO data.). In a voluntary system, especially one that guarantees the right of later entry, and that continues to provide some uncompensated care, the rational choice for the average male under 30 years of age is not to participate. This will of course trigger an anti-selection spiral that will destroy the under 30 voluntary market.

Laura Tyson, *quoted in Clinton Insists He Won't Retreat on Coverage for All*, N.Y. TIMES, Jul. 21, 1994, at B9, did roughly outline these objections to market reforms without compulsory insurance.

<sup>331</sup> *See* LAMa1, *supra* note 320, art. 61, § 2.

<sup>332</sup> *See id.* § 3.

<sup>333</sup> *See id.* § 1.

<sup>334</sup> *See id.* § 4.

As the analysis above suggests,<sup>335</sup> the fewer the rating categories permitted, the more the insurance program is social in nature. Equal premium rates for all insureds means that the healthy subsidize the sick, the young subsidize the old, and men subsidize women.

Article 7, Section 1 permits insureds to change insurers at will, with three months notice.<sup>336</sup> In the case of a premium increase, insureds may change insurers with one month's notice.<sup>337</sup> These provisions will certainly increase the importance of low premiums to the survival of an insurance fund, and almost certainly prefigure consolidation among medical benefits insurers.<sup>338</sup>

### S. *Guaranty Fund*

Article 18 creates a national insurance guaranty fund to assure payment of the obligations of insolvent insurers and to assume other duties delegated to it by the Federal Council.<sup>339</sup> Insurer payments fund insolvency obligations,<sup>340</sup> while the Federal Council determines the funding of the duties it delegates.<sup>341</sup>

### T. *Preventive Medicine*

Article 19, Section 1 makes the promotion of preventive medicine an insurer obligation.<sup>342</sup> The cantons and the insurers collectively, or, if they fail to act, the Federal Council, will create an agency for this purpose.<sup>343</sup> Its board of governors will contain members representing the numerous constituencies affected by health care policy.<sup>344</sup> Part of

<sup>335</sup> See *supra* notes 294–303.

<sup>336</sup> See LAMa1, *supra* note 320, art. 7, § 1.

<sup>337</sup> The insureds notification window begins on the last day of the month in which the insured receives the insurer's notification of the premium increase. See *id.* § 2.

<sup>338</sup> Funds must consolidate until the cost profiles of the remaining funds are the same. If they do not consolidate, the more expensive funds will lose members to the less expensive funds, which will likely make them more expensive still, due to lost economies of scale. Similar costs will require similar risk pools, which will in itself require groups large enough to track overall population statistics. See Swiss Reform, *supra* note 73, at 7. Small medical cost differentials can be overcome by offsetting expense efficiencies. See *id.* In a country as small as Switzerland, I would guess that no more than five or six funds per area would ultimately survive, compared to the approximately two hundred in existence in 1994. See *id.*

<sup>339</sup> See LAMa1, *supra* note 320, art. 18, §§ 1–3.

<sup>340</sup> See *id.* art. 18, § 5.

<sup>341</sup> See *id.* § 6.

<sup>342</sup> See *id.* art. 19, § 1.

<sup>343</sup> See *id.* §§ 2, 3.

<sup>344</sup> See LAMa1, *supra* note 320, art. 19, §§ 2, 3.

the premium for medical benefits insurance will be used to support this preventive medicine agency.<sup>345</sup>

#### IV. COST CONTAINMENT

##### A. Policy

The new law has many provisions aimed at cost containment. Article 22 limits insurer expenses to those necessary for economical management<sup>346</sup> and subjects them to the oversight of the Federal Council, including, if necessary, restraints on salaries and prices.<sup>347</sup> Article 32, Section 1 mandates that treatments reimbursed have been provided as economically as possible and that they be proved effective by scientific analysis.<sup>348</sup> Article 33 specifically delegates to the Federal Council the designation of procedures not eligible for reimbursement.<sup>349</sup> It also delegates to the Council the determination of how to reimburse for experimental treatments.<sup>350</sup> Article 39 imposes a cantonal "certificate of need" obligation on inpatient facilities.<sup>351</sup> Although Article 41, Section 1 reaffirms commitment to an insured's free choice of provider, Section 3 of the same Article permits insurers to offer limits on choice in exchange for lower premiums.<sup>352</sup>

##### B. Fees

As under the old law, provider prices are determined by negotiation between providers and insurers.<sup>353</sup> However, both the negotiators and the public authorities with oversight responsibility are urged to bear in mind that, while the quality of care should be high, its cost should

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<sup>345</sup> See *id.* art. 20, § 1.

<sup>346</sup> See *id.*

<sup>347</sup> See *id.* § 2.

<sup>348</sup> See *id.*, art. 32, § 1. This is a very stern test which will almost certainly be impossible to enforce. Truly scientific tests require control groups. Medical ethics and public opinion prohibits leaving some sick persons untreated as a way of determining the cost-effectiveness of treatment. However, if what the law suggests is that any new treatments must be proved cost-effective compared to existing therapies before they will be reimbursed by social insurance, it could be important in reducing costs.

<sup>349</sup> See LAMa1, *supra* note 320, art. 33, §§ 1, 2.

<sup>350</sup> See *id.* § 3.

<sup>351</sup> See *id.* art. 39, § 1(d).

<sup>352</sup> This makes permanent the experiment with alternate delivery mechanisms discussed above. See *supra* text accompanying notes 287-92.

<sup>353</sup> See LAMa1, *supra* note 320, art. 43, § 3.

be as low as possible.<sup>354</sup> The law assigns to the Federal Council the responsibility of establishing procedures for setting fees.<sup>355</sup>

Article 46 prohibits a variety of provider arrangements that could have the effect of artificially inflating fees.<sup>356</sup> For example, Article 46 prohibits separate contracts and exclusivity clauses, agreements that would violate U.S. anti-trust law.<sup>357</sup> It also subjects fee schedule agreements to the approval of cantonal or federal authorities, as their area of application warrants.<sup>358</sup>

Article 49 requires hospitals and insurers to negotiate reimbursement contracts.<sup>359</sup> It limits charges to insurers for use of public hospitals to 50% of the costs of care for those hospitals, where cost of care excludes the costs of investment, research, and overcapacity.<sup>360</sup>

### C. *Other Provisions*

Providers who accept any remuneration from the social medical benefits program must accept it as payment in full; no balance billing is permitted.<sup>361</sup> A physician who does not participate in the social insurance program must so inform an insured patient before providing any treatment.<sup>362</sup> The law appears to anticipate substantial provider resistance. If the refusal of providers to participate in the social medical benefits program jeopardizes adequate treatment of those insured by it, Article 45 authorizes the cantonal authorities to take whatever action necessary.

### D. *Other Cost Containment Measures*

Article 51 permits cantons, after consulting with providers, to impose a global budget as a way of controlling in-patient costs.<sup>363</sup> Article 54 permits insurers to insist upon a global budget for hospitalization if the rate of increase in hospitalization costs in the canton has exceeded the national average.<sup>364</sup> Article 55 permits the appropriate authorities

<sup>354</sup> *See id.* § 6.

<sup>355</sup> *See id.* §§ 7.

<sup>356</sup> *See id.* art. 46, § 3.

<sup>357</sup> *See id.*

<sup>358</sup> *See* LAMa1, *supra* note 320, art. 46, § 3.

<sup>359</sup> *See id.* art. 49

<sup>360</sup> *See id.*

<sup>361</sup> *See id.* art. 44, § 1.

<sup>362</sup> *See id.* § 2.

<sup>363</sup> *See* LAMa1, *supra* note 320, art. 51.

<sup>364</sup> *See id.* art. 54.

to freeze prices within a segment of the health care industry when cost increases have grown at twice the rate of the general increase in wages and prices.<sup>365</sup> The freeze lasts until the rate of growth in the affected segment has declined to no more than half that of the general increase in wages and salaries.<sup>366</sup>

### E. *Role of Government*

In default of a negotiated agreement, the cantonal authorities can unilaterally decree a schedule after consulting with interested parties.<sup>367</sup> If negotiators cannot reach agreement when renegotiating an existing fee schedule, the cantonal authorities can extend the old schedule for one year.<sup>368</sup> If at the end of that period, an agreement has still not been reached, the canton can, as in default of an initial agreement, promulgate a schedule after consultation with interested parties.<sup>369</sup>

Article 53<sup>370</sup> provides a right of appeal to the Federal Council from decisions of cantonal governments about: (1) the eligibility of hospitals for reimbursement by compulsory health insurance (Article 39);<sup>371</sup> (2) actions to assure health care access (Article 45);<sup>372</sup> (3) certification of fee schedules (Article 46, Section 4);<sup>373</sup> (4) imposition of a fee schedule when providers and insurers fail to negotiate one (Article 47);<sup>374</sup> (5) establishment of fee minimums and maximums (Article 48, Sections 1 to 3);<sup>375</sup> (6) adjudication of appropriateness of hospital charges (Article 49, Section 7);<sup>376</sup> (7) establishment of a global budget for hospitals (Article 51);<sup>377</sup> (8) adjudication of a demand from insurers for a global

<sup>365</sup> *See id.* art. 55.

<sup>366</sup> *See id.* Of course, utilization increases can cause costs to rise in a given health care segment even when unit prices stay the same. For example, if the cost of the average prescription stays constant at \$30 per prescription, but the average number of prescriptions per insured person rises from four to four and one-half, the cost per person for prescription drugs rises from \$120 to \$135.

<sup>367</sup> *See id.* art. 47, § 1.

<sup>368</sup> *See* LAMa1, *supra* note 320, art. 47, § 3.

<sup>369</sup> *See id.*

<sup>370</sup> *See id.* art. 53.

<sup>371</sup> *See id.* art. 39.

<sup>372</sup> *See id.* art. 45.

<sup>373</sup> *See* LAMa1, *supra* note 320, art. 46, § 4.

<sup>374</sup> *See id.* art. 47.

<sup>375</sup> *See id.* art. 48, §§ 1-3.

<sup>376</sup> *See id.* art. 49, § 7.

<sup>377</sup> *See id.* art. 51.

budget for hospitals (Article 54);<sup>378</sup> and (9) installation of price controls (Article 55).<sup>379</sup> Other than those changes, the new proposal strongly resembles the law of June 13, 1911, which it replaces.

### F. *Trends in Health Care Costs and Financing*

Nowhere, except in the United States, has the pressure exerted by the inexorable rise in health care costs been as great as in Switzerland. From 1985 to 1995, growth in health care spending outpaced growth in gross domestic product by 22%.<sup>380</sup> By 1994, the Swiss had achieved the dubious distinction of attaining second place, surpassed only by the United States, both with respect to the percentage of their GNP devoted to health care, 9.9%,<sup>381</sup> as well as with respect to per capita costs.<sup>382</sup>

While costs themselves continued to climb, the government's share of health care costs fell.<sup>383</sup> I theorized above that the proportion of health care costs financed by the state was 40% or higher on introduction of premium subsidies in 1911.<sup>384</sup> The 1964 amendments to the 13 June 1911 Act set the level of subsidy at 10% for adult men, 35% for adult women, and 30% for children fifteen years old and under.<sup>385</sup> Economic recession and spiraling medical inflation, even before the most recent surge in costs, had led the Swiss government to abandon the percentage contribution scheme adopted in 1964.<sup>386</sup> Per capita contributions were frozen in 1979,<sup>387</sup> reduced 5% in 1981,<sup>388</sup> and eliminated, for middle-class recipients, by LAMal. According to J. Matthias Graf v. d. Schulenberg, in 1981, federal subsidies amounted to 19% of

<sup>378</sup> See LAMal, *supra* note 320, art. 54.

<sup>379</sup> See *id.* art. 55.

<sup>380</sup> *Les coûts de la santé dépassent la croissance économique*, 96:6 CAMS ACTUEL 89, 90. CAMS ACTUEL is a publication of the Concordat of Swiss Health Insurers. All the articles from CAMS ACTUEL from which I quote were among the materials provided to me by Markus Moser. See *supra* note 178.

<sup>381</sup> See *supra* note 147 and accompanying text.

<sup>382</sup> *Dépenses de santé: la Suisse en deuxième position*, 96:9 CAMS ACTUEL 130.

<sup>383</sup> See WILLIAM A. GLASER, HEALTH INSURANCE IN PRACTICE 189 (1991); J. MATTHIAS GRAF V. D. SCHULENBERG, DEREGULATION OF STATUTORY HEALTH INSURANCE: THE EFFECTS OF INCREASED COST-SHARING ARRANGEMENTS 16 n.20 (1984).

<sup>384</sup> See *supra* notes 253–55 and accompanying text.

<sup>385</sup> See 13 JUNE 1911 ACT, *supra* note 211, amended by 1964 Amendment, *supra* note 257, arts. 36, 37.

<sup>386</sup> See *supra* notes 283–84 and accompanying text.

<sup>387</sup> See SWISS HEALTH INSURANCE, *supra* note 288, at 40.

<sup>388</sup> GLASER, *supra* note 383, at 189.

the total income of Swiss sickness funds.<sup>389</sup> According to Glaser, in 1985, the federal subsidy was only 10%.<sup>390</sup> Based on my own estimate of 1996 health care spending,<sup>391</sup> on the division of costs by sector in 1993,<sup>392</sup> and on the estimate of Federal Office of Social Insurance of 1996 premium subsidies,<sup>393</sup> by 1996, the first year of LAMal, the federal subsidy fell to less than 7%.

Decreasing cantonal support for health care has exacerbated the effect on Swiss health insurance premiums of the declining percentage of premiums subsidized by the federal government. The Swiss cantons were slow to take up any of the slack in government contributions created by past federal retrenchment.<sup>394</sup> Sixteen cantons failed to qualify at all, or did not qualify for the full amount to which they were entitled based on population, for the matching funds provided by the Federal Decree on Temporary Measures to Protect Solidarity.<sup>395</sup> Three cantons received their due, while seven others actually received more, beneficiaries of amounts not distributed to the non-qualifying cantons.<sup>396</sup>

In 1993 alone, cantonal spending on health care declined by 4%.<sup>397</sup> Over the period 1992–1994, public hospital costs rose by a total of 7.5%. Charges for hospital services to health insurers rose by 28.5%: “The cantons reduced their hospital deficits at the expense of [health insurance] premium payers.”<sup>398</sup> The 50% maximum enacted in LAMal Article 49 has served, quite predictably, more as a target than as a spur to eliminate overcapacity.<sup>399</sup>

Health insurance premiums have long been a large and visible part of the outlays of the Swiss household.<sup>400</sup> According to the Swiss Depart-

<sup>389</sup> See GRAF V. D. SCHULENBERG, *supra* note 383, at 16 n.20.

<sup>390</sup> See GLASER, *supra* note 383, at 189. However, it does not seem that these figures can be strictly comparable.

<sup>391</sup> I projected the provisional estimate for 1995, 35,600 millions Swiss francs, to 1996 using as a projection factor the rate of growth for 1995 over 1994 (35,600/33,730. See *36 milliards pour la santé*, 96:5 CAMS ACTUEL 68, 69. That produced an estimate for 1996 of 37,607 million francs.

<sup>392</sup> See *id.* at 68.

<sup>393</sup> 1,813 million Swiss francs. See *L'OFAS s'exprime sur des questions relatives à LAMal: Exposé de M. Walter Seiler, directeur de l'OFAS*, 96:2 SÉCURITÉ SOCIALE 85, 86 (1996).

<sup>394</sup> See GLASER, *supra* note 383, at 189–90.

<sup>395</sup> See Swiss Reform, *supra* note 73, at 28.

<sup>396</sup> See *id.*

<sup>397</sup> See *36 milliards pour la santé*, *supra* note 391, at 68, 69.

<sup>398</sup> See *Pas de hausse des tarifs hospitaliers, mais moins de lits*, 1/2:96 CAMS ACTUEL 4, 5.

<sup>399</sup> See *id.*

<sup>400</sup> See OECD, *THE REFORM OF HEALTH CARE SYSTEMS: A REVIEW OF SEVENTEEN OECD COUN-*



ment of the Interior, the average increase in premiums for 1997 was 12%, far greater than the growth in income.<sup>401</sup> These rapid, steep increases in premiums have quite understandably generated widespread discontent.<sup>402</sup> Although a consensus for further change seems unlikely to emerge soon, proposals for change have arisen from a variety of sources.<sup>403</sup>

### G. Can LAMal Contain Costs?

The freedom available to insureds under LAMal to change health insurers<sup>404</sup> creates a tremendous incentive for health insurers to contain costs. Certainly, an insurer capable of negotiating lower fees would gain a competitive advantage which would sharply increase market share. The new law enables insurers to offer reduced access for lower prices.<sup>405</sup> Network products will inevitably make their presence felt.<sup>406</sup>

In the shorter term, insurers must turn to the government to enforce the cost-cutting provisions of the new law, especially those that prohibit passing the costs of overcapacity on to insurers.<sup>407</sup> The Swiss cantonal authorities have substantial statutory power over rate-setting.<sup>408</sup> However, the financial stake that they have in the outcome of rate negotiations leads to higher costs for compulsory insurance.<sup>409</sup> If the new law is to succeed in cutting the rate of growth in health care costs in the shorter term, the Federal Council will need to make full use of its right to settle appeals made to the Council.

TRIES (1994) 289. By 1993, over 50% of Swiss households devoted more than 8% of their income to the payment of health insurance premiums. *See id.* Given the sharp increases of recent years, the modal contribution will have risen substantially. *See 36 milliards pour la santé, supra* note 391, at 68–69.

<sup>401</sup> *See* DÉPARTEMENT FÉDÉRAL DE L'INTÉRIEUR, ENTRETIENS DE WATTENWYLL 2 (Nov. 1996) [hereinafter WATTENWYLL].

<sup>402</sup> *See id.* at 1.

<sup>403</sup> *See Entre extension des prestations et coups de frein aux coûts*, 96:12 CAMS ACTUEL 192.

<sup>404</sup> *See supra* note 335 and accompanying text.

<sup>405</sup> *See* LAMal, *supra* note 320, arts. 32, 33, 39, 41; *see also supra* notes 347–51 and accompanying text.

<sup>406</sup> *See* WATTENWYLL, *supra* note 401, at 2.

<sup>407</sup> *See* LAMal, *supra* note 320, arts. 44, 47.

<sup>408</sup> *See supra* notes 357, 362, 363, 365, 367, 369 and accompanying text.

<sup>409</sup> *See supra* note 398 and accompanying text. To quote from the text prepared by the Department of the Interior for distribution to participants in a November 1996 conference at Wattenwyll between the Federal Council and members of the parties making up the government, "[t]his state of affairs demonstrates that the federal authorities cannot content themselves with a wait-and-see policy." WATTENWYLL, *supra* note 401, at 7.

## V. CONCLUSION

Perhaps more than any other factor, separation of powers gives "federalism"<sup>410</sup> in the American form of government greater substance than it has in Canada. A parliamentary form of government, at least with strong, national parties, tends to mute expression of regional interests at the national level. The need for, and habit of, party discipline, tends to make regional variation a factor in the formulation of a party program, but not in its enactment, in both houses of a federal legislature, whatever the aspirations of the drafters of the national constitution may have been.

In the United States, the separation of executive and legislative power, and the frequency with which different parties have controlled one of these two branches of government, has made the members of both houses of Congress more responsive to local interests, if not to their states as co-sovereign entities.<sup>411</sup> In this respect, the House of Representatives is more responsive to local interests than the Senate.

The United States, now that the Russian Empire has finally dissolved into its constituent parts, seventy years after the death of Czar Nicholas II, is the most diverse country in the world, considered along almost any axis of identity except the linguistic. Considered racially, and by ethnic group within race, religiously, and politically, Americans appear at every point along each spectrum. These differences are not accepted in the United States with the same tolerance with which the Swiss, for example, have always accepted their differences in language and, more recently, their differences in religion.

Switzerland comes closer in many relevant respects to the United States than Canada. It is diverse with respect to language and religion. It is governed at the federal level by a stable coalition which operates by consensus, which comes closest among the systems we have examined to approximating the habitual compromises necessary to enact legislation in the United States. The referenda powers give localities greater real power than they possess elsewhere.

The Swiss health care system establishes national standards for qualification for the mandatory program of health insurance. It permits

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<sup>410</sup>I define "federalism" weakly, as the power of local interests to determine national policy. Federalism in its classic sense, as the power of the states as sovereign entities to share in the determination of national policy, died in the United States, if it ever existed, with the Civil War.

<sup>411</sup> See, e.g., MORRIS P. FIORINA, CONGRESS 49 (2d ed. 1989).

the cantons further to shape the health program within their jurisdictions. The benefits which must be provided in order to qualify the mandatory program are more comprehensive than Hillary Clinton has ever dreamed of for an American program of reform.

A program that gives the states as much flexibility as the Swiss give the cantons seems appropriate to American diversity. It would seem to have greater political appeal than many of the options currently discussed. Its form might easily resemble the original form of the Canadian federal legislation, without the bias that legislation had toward administration by the provincial government. That is to say, the states could have the freedom to enact even voluntary programs as long as their programs succeeded in covering 95% of the population and provided a minimum level of benefits. Such a high threshold would almost certainly require a compulsory program in almost every jurisdiction.

The federal government would guarantee to maintain its current level of contributions to qualifying programs, but would revise the form of its health care subsidies along lines I have suggested elsewhere.<sup>412</sup> The states would be given a direct stake in the cost-effectiveness of their programs by assigning residual costs to them, as in the Canadian provinces. The states would have the power to impose an employer mandate or not, to require different delivery mechanisms, to prohibit balance billing, and to impose fee schedules, among other things.

Perhaps the most important power the states must have, however, is the power to impose a global budget. Permitting state variation may be the only way to gain global budgeting in any jurisdiction. It is possible that American reform could succeed in containing costs even without global budgeting. The diversity of delivery mechanisms, which includes totally integrated systems like staff model HMOs with salaried providers and owned hospitals, along with full payment by insureds of any differential costs of the plan they choose, could be enough to make competition effective in containing delivery costs. State experimentation with a wide variety of delivery systems could also help establish the most effective forms of administration.

The United States is indeed unique. However, only fools fail to learn from the experience of others. The experience of the countries we have examined should prompt us to temper our optimism for the

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<sup>412</sup> See Donahue, *supra* note 1, at 170–80.

outcome of any program of reform, which should itself recommend state experimentation. If we let fifty flowers bloom, some of them may survive long enough to prove themselves worthy of being transplanted.