

Swiss and Dutch “Consumer-Driven Health Care”: Ideal Model or Reality?¹

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Abstract

This article addresses three topics. First, it reports on the international interest in the health care reforms of Switzerland and The Netherlands in the 1990s and early 2000s that operate under the label “managed competition” or “consumer-driven health care.” Second, the article reviews the behavior assumptions that make plausible the case for the model of “managed competition.” Third, it analyzes the actual reform experience of Switzerland and Holland to assess to what extent they confirm the validity of those assumptions. The article concludes that there is a triple gap in understanding of those topics: a gap between the theoretical model of managed competition and the reforms as implemented in both Switzerland and The Netherlands; second, a gap between the expectations of policy-makers and the results of the reforms, and third, a gap between reform outcomes and the observations of external commentators that have embraced the reforms as the ultimate success of “consumer-driven health care.” The article concludes with a discussion of the implications of this “triple gap.”

1 Introduction

Switzerland and The Netherlands, two small Western European countries with populations of 8 and 16 million respectively, have figured prominently in the health policy literature as leading examples of “consumer-driven health care”. Switzerland (in 1996) and Holland (in 2006) introduced a mandate for all legal residents to take out (private) health insurance, replacing pre-existing public and private insurance. Those reforms, heralded as cost-saving measures and typically described as instances of “managed competition,” prompted great interest abroad [1-6]. Some commentators embraced the “Dutch market model” as a solution for the United States [4,7]. Naik [4] described the Dutch system as “...a model of competition and a small dose of regulation,” with “individuals buying coverage”.... “that replaced ‘state-run schemes’.” Gruber [8] claimed that “(n)ations like The Netherlands and Switzerland....have achieved universal coverage within a private insurance structure, ... [and] ... control costs better than we do.” Other commentators, however, argued that government regulation, not competition, had been the major

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factor in controlling health expenditure [9]. Finally, Krugman [10] explained the essential features of Obamacare to US citizens as follows: “Basically, it’s a plan to Swissify America, using regulation and subsidies to ensure universal coverage”.

In the meantime, other countries have sought to follow the Dutch and Swiss reforms. For example, in early 2012, the Irish government announced its intention to implement the Dutch insurance model within 5 years [11]. Likewise, governments in Spain (especially Catalonia) and Germany [12] have expressed serious interest in the insurance mandate.

The Theory of Managed (Regulated) Competition

What precisely constituted this policy model? According to one commentator: “...the essence of regulated competition is to introduce competition while upholding fundamental social values in health care, in particular solidarity in health care financing and universal access to health care” [13]. Mentioning *purposes* claimed for managed competition, however, does not explain how regulated (or managed) competition is supposed to work to realize such goals. Other commentators assume there is enough general agreement about the meaning of managed competition to use the term without further explanation [e.g. 6, 14].

The core assumptions underlying the theory of “managed competition” or of “consumer-driven health care” appear in practice to be fourfold. First, cost-conscious and well-informed consumers who are mandated to take out health insurance will, it is taken for granted, shop around for an insurance plan that best satisfies their (current and future) health care wants.² Second, responding to that pressure, (competing) health insurers will act as prudent buyers of patient-friendly, higher quality and cheaper services on behalf of their insured. Third, health care providers will compete on price, quality and consumer responsiveness. And four, government will (largely) step back, letting the market forces allocate scarce resources efficiently [2, 15, 16]. Based on all those (theoretical) assumptions, the major actors in the health care domain should be willing and able to play their attributed role in order to reach the desired outcomes of managed competition: an efficient allocation of scarce resources for health care services that satisfy the needs and demands of patients and insured and help control health expenditure.

But are those assumptions--and the label “consumer-driven health care”--warranted? What explains the particular health reform pathways in Switzerland and The Netherlands? What happened in the two countries after they introduced the insurance mandates? The Dutch reforms

“allocated an important role to patients or consumers” [5]. Does that mean that Dutch health insurers nowadays organize health care in a way that patients or insured find most attractive? Or do they restrict patient choice by selectively contracting cheaper or perhaps more cost-effective care? Do they manage care, or manage costs? Did they really create “integrated delivery systems” as Van de Ven and Schut [7] appear to claim? And, importantly, should the Swiss and Dutch experiences encourage other countries to follow suit?

To address those questions, this contribution combines economic, political and policy analysis. It assesses both the claims in the literature and the realities of managed competition in Swiss and Dutch health care. It describes the current health care systems of both countries, concentrating on the financing, contracting and provision of health care services as well as administration and government regulation (see [17] for a discussion of those “core elements” of health care systems). Theories of path dependency (with rare “windows of opportunity” for major change) and notions of “voice” and “exit” [18] help explain the particular health reform pathways and outcomes of the two nations.

2 Switzerland and The Netherlands: “Consumer-Driven Health Care”?

Switzerland and Holland—like the majority of other countries in Western Europe—share the goals of safeguarding universal access to good quality health care while restraining public expenditure. The two countries share a legacy of social insurance, one based on an (implicit) social contract between state and society, with powerful expectations that governments are--and will remain--responsible for making health care accessible for all citizens. Both nations have since the 1970s had lengthy debates about the future course of their health care systems. In the end, both implemented population-wide mandates requiring individual citizens to buy (private) health insurance. In both countries, strong veto powers of organized stakeholders forced governments to adjust, slow down or even abandon health reform efforts [19, 20].

There are of course major differences in the political systems of the two countries. Switzerland is a federal state that delegates much social policy-making to the Canton level whereas Holland is a unitary state. The Dutch parliamentary democracy--with coalition governments that require consensus and compromise—faces pressure to soften the consequences

of policy measures. Despite the differences, the reform processes in both countries reveal several similarities.

Switzerland

Switzerland is a highly decentralized Federal State composed of 26 Cantons. It combines a tradition of social security with direct democracy (referendum and popular vote) and a liberal economic culture that together provide a high degree of “voice” and “exit” opportunities to its citizens [20]. Private stakeholders are systematically involved in decision-making, by institutionalized participation mechanisms at the political level (consultation procedure), through strong lobbying activity in the Parliament as well as by the right to be represented in the different control and management agencies [21]. The long tradition of “*médecine libérale*” (physicians’ freedom to establish practice, and patients’ free choice of physician or hospital) has hindered efforts to rein in hospital capacity or control costs. Together, those features have resulted in a rapid rise of overall health expenditure as well as large regional variations in hospital capacity [22], health care expenditure [23], and financial burdens to families [24, 25]. They also resulted in seemingly insurmountable barriers to nation-wide reform.³

Swiss residents have been required to purchase basic health care coverage with one of the many insurers since 1996. Most health insurers have shed their traditional identity as regional, religious, or occupation-based social insurance agency, and operate now as national commercial firms [26]. They face extensive federal government regulation: they all have to offer the same range of basic entitlements, charge community-rated premiums, cannot engage in underwriting; moreover, they have to be not-for-profit entities as long when offering compulsory cover. They have to contract with all health care providers in the Cantons where they operate, and insured citizens have virtually unlimited choice of health care provider. Cantons are responsible for the planning of hospitals and long term care facilities as well as the supervision of health insurance. The latter includes the monitoring of adherence to the health insurance mandate, and the distribution of fiscal subsidies to low income families for purchasing insurance.

Health insurers receive budget allocations that compensate for differences in their portfolio; until 2011 risk adjustment was based on rather crude criteria and considered only gender and age classes. Starting from 2012 the formula has been improved and takes now into

account as additional factor the hospitalization or stay in a nursing home of at least three days in the previous year [27, 28]. Low-income families can apply for state subsidies to purchase health insurance (though the amount has not kept pace with the rising premiums). The share of fiscal subsidies in total premiums was 16% in 1996, raised up to 20.6% in 1999, declining to 18% in 2010. Between 1998 and 2009 average health insurance premiums grew by 63%, average household income only by 12%.

Swiss insured can opt for alternative plans with lower premiums. These plans entail selective contracting, gate-keeping by general practitioners, and models that imply financial incentives to providers for complying with practice guidelines [29, 30]. The membership of such alternative “managed care” plans rose from 2 to 8 per cent between 1996 and 1997, but that growth leveled off in the next decade [31]. When insurers started to offer a double premium discount for managed care contracts with a high deductible, the share went up again and reached 46.9 percent in 2010. The switching rate (in particular, “partial exit” to another plan within the same insurance holding) rose to 12 percent in 2009 and to 15% in 2010. As in other countries, such plans tend to attract younger, healthier, wealthier and better-informed people [27, 32]. In reaction, Swiss Parliament passed stricter regulation of managed care plans (under the title “integrated networks of care”) in September 2011, but the legislation was swept away by the citizens in the referendum held on June 17th 2012.

There is ample hospital capacity in Switzerland, in 2010 with over 120 acute hospitals and 180 private clinics providing their services to the 8 million habitants. The average length of stay is high compared to the surrounding countries, and total hospital expenditure of Switzerland is amongst the highest in Europe [33]. Medical specialists work in hospitals or in private practice. Self-employed health professionals receive fee for service payments. Hospital incomes are based on DRG-based payment (covered by health insurers and cantonal taxes in a 45-55 proportion) as well as fee-for-service payment for outpatient care. All health care faces extensive government regulation of federal and cantonal authorities.

The Netherlands

The rules of the 2006 insurance mandate in Holland are similar to those in Switzerland. All legal residents have to take out basic health insurance. The goods and services (entitlements) of the

basic coverage more or less equal those of the former social health insurance. In fact, the term “basic” is somewhat misleading since the mandatory coverage includes a wide range of health care goods and services. Efforts in the last decade to de-list entitlements from the social health insurance in Holland (as elsewhere) have not been very successful. They are, in fact, a “catalogue of failure” [34].

All Dutch insurers have to offer the same basic entitlements defined by government, but they can—and do—offer a wide variety of supplemental plans. All insured face a mandatory deductible of about 170 euros per year (in 2011); they can opt for a higher deductible plan with lower premium. In 2011, total health expenditure including the long term care insurance (see below) amounted to over 80 billion euros, 5,000 euros (or US\$ 6,500) per capita. The Dutch pay for medical care and insurance via different ways. All insured pay a flat-rate premium directly to their insurer. In 2012, the 48 legally independent insurers all charged between 92 and 118 euros per person per month for the basic coverage. Second, employers withhold income-related contributions (in fact, earmarked taxes) from the pre-tax income of their employees (in 2012, 7.1% over the taxable income up to a ceiling of 50,064 euros). Self-employed pay earmarked taxes. Third, general taxes finance the flat rate insurance premium for people younger than 18, subsidies for medical research and education, the development of information technology, public health and many other activities. Fourth, almost 90% of Dutch insured have taken out supplemental insurance of services excluded from basic coverage, such as cosmetic surgery, dental care for adults or alternative medicine. Fifth, there is a separate population-wide social insurance for long-term care (including long term stay in nursing homes and other specialized institutions, mental care and some other entitlements), the General Long Term Care Act, the *Algemene Wet Bijzondere Ziektekosten* (AWBZ). All legal residents paid 12.15 % of taxable income up to 33,400 euros as AWBZ contribution in 2010. Finally, patients face user fees for some drugs and medical treatments, or out of pocket payment for services excluded from the basic (in fact, a 100% co-payment).⁴ In general, however, Dutch patients face modest user fees. Co-payments were the lowest of all OECD member states in 2010 (OECD Health Data 2011). Low-income families can apply for fiscal subsidy to purchase health insurance, with a maximum of 835 euros in 2012⁵. Remarkably, over 50% of the Dutch population qualified for this subsidy.

Dutch Insurers face similar regulations as their Swiss counterparts, with two major differences: the former can choose to act as for-profit or not-for-profit entities, and they do not

have to contract all providers in their region. Like their Swiss counterparts, they cannot turn down anyone seeking coverage, and have to charge community-rated premiums. They can offer alternative plans with different financial conditions, however, for example a higher deductible (with a legal maximum of 500 euros in 2011) in exchange for a lower premium. Insurers in both countries receive compensatory subsidy for over-representation of high-risk (or high-cost) insured based on an elaborate risk-adjustment formula (in both countries, the formula tends to become more elaborate, and more expensive to administer in a search to improve the risk-predicting capacity of the model).

The process of implementing the new insurance regime has been complicated and difficult. For example, the number of uninsured and delinquent payers (that insurers could strike from their rolls after 6 months of non-payment) went up sharply after 2006. At first, the Health Ministry decided that any uninsured admitted to a hospital would have to pay the bill, take out insurance retroactively and face a substantial fine as well. But after an expert study found that young immigrants, welfare recipients and single mothers were overrepresented in the uninsured population, the MoH changed course. It set up a separate risk pool that basically took over the risks from insurers, but later reinstated the fines. The number of uninsured dropped to about 1 percent of the population, but (as in Switzerland) the number of delinquent payers (who had failed to pay their premiums for over 6 months) rose sharply, to 280,000 or 1.7 percent of the population in 2010 [6]. As Glied and her colleagues [35] conclude, mandates are hard to enforce.

In contrast to Switzerland, Dutch insurers can selectively contract with providers. Yet they have been reluctant to break off long-standing contractual relations (perhaps illustrating that “exit” is difficult in a small country, where the different actors in health care have long-lasting relations). Anticipating on the new scheme, both insurers and providers strengthened their market positions by merging with others in the 1980s and 1990s [19]. The announcement of the 2006 reforms accelerated this process of market concentration. There were 48 legally independent health insurers in 2012, most under the umbrella of large banking and insurance conglomerates. In fact, four of those conglomerates captured almost 90% of the entire health insurance market [36]. As health care providers, too, sought to defend or expand their market share, several bilateral market monopolies of insurers and providers emerged that all but defeated government competition policy in health care.

The number of independent hospitals in Holland had dropped from over 200 in the early 1980s to about 100 by the turn of the century, after government encouraged hospitals to merge with others (often as a precondition for investing in new buildings that also reduced capacity). There are hundreds specialized health and long-term care facilities including nursing homes and residential homes for handicapped persons that provide medical treatment and long term care, and home care organizations. The majority of those facilities are non-profits, but there has been a rise of for-profit health care since the 1990s. Most of the 7,000 or so general practitioners work in solo practice or small group practices as self-employed practitioners. Medical specialists often work in small groups that have contracts with hospitals, but growing numbers of (younger) specialists have employment contracts. As in other countries, the last three or four decades have seen almost permanent battles over payment modes and payment levels as well as professional autonomy of physicians.

3 Outcomes of Consumer Driven Health Care in Switzerland and The Netherlands

There are at least five outcomes “managed competition-”reforms in Holland and in Switzerland worth mentioning. First, total health care spending, as well as health insurance premiums, went up considerably after the implementation of the insurance mandate (table 1 and 2 below). Both countries were well below the OECD average in the 1970s. In Switzerland, total health expenditure rose from about 9.6 percent to 11.2 percent of gross domestic product between 1995 and 2005. Similarly, those costs in The Netherlands increased from 9.7 to over 12 % of GDP between 2005 and 2010 according to the OECD Health data. One of the problems of assessing data over time, however, is the changing definition of health care services listed as health expenditure. But still, the general trend of high medical inflation did not reverse after the introduction of the insurance mandate in either country. By themselves, those increases are no proof of failure or success of the new model of “consumer-driven health care” in either country as it is hard to attribute behavioral changes to any specific policy measure. But the high expenditure growth does not suggest a major success in cost control either to say the least. Some proponents of the market-oriented changes in Holland pointed to the fact that the *prices* of the 20% or so share of hospital care under the financial responsibility of insurers has gone up somewhat less than the 80% of hospital expenditure that remained under direct government price

control [6, 37]. At the same time, the *volume* of the former services went up disproportionately [6, 13].

table 1 about here

table 2 about here

Second, relatively low and skewed consumer mobility has been another common result. In 2007, about one fifth of Dutch insured changed insurer, mostly via collective contracts. The next years, however, less than 5 per cent did so, and over 80 percent of those changed plan under a collective employment-based contract [36]. Thus in fact, less than one per cent of the population acted as individual consumers. If anything, the new scheme *strengthened* the role of Dutch employers in the health insurance (as they took a more active role in selecting plans for their employees, both the former sick fund members and previously private insured), even while its basic underlying notion is that of individual choice. Likewise, Swiss citizens initially showed little interest in shopping around for health insurance [38, 39]. Less than 3 percent switched in 2007, but the switching rate rose to 12 percent in 2009 and to 15% in 2010, in particular after insurers offered a double rebate for managed care plans with high deductibles. “Partial exit” (to another plan with the same insurer) occurred more frequently, mostly in high deductible plans (with deductibles of over US\$ 720 per year). Predictably, in both countries, young, relatively wealthy and healthy insured changed plan more often than others. Thus, in fact, persons who need health care most – the elderly, disabled or chronic ill – were the *least* likely to act as consumers forcing insurers to improve their contracts with health care providers. In both countries, the fact that younger and healthier insured (attracted by lower premiums rather than better quality or “integrated care”) switched plan more often than the older or sicker groups suggests a form of self-selection rather than active consumerism that would help improve the quality of health care or the collaboration between providers. There is no evidence in either Holland or Switzerland that older and sicker patients are organizing themselves into associations that reflect their interest or willingness to become active health insurance “consumers.”

Third, the numbers of uninsured and delinquent payers went up after the introduction of the insurance mandates. The Swiss government imposed very strict (and some would argue,

intrusive) administrative rules to safeguard adherence to the insurance mandate. Canton authorities compare the data of health insurers with the regional population registry, and when they find discrepancies, they urge individuals to take out insurance (or face fines). Still, with that strict control, there were rising rates of non-payment in 2010 [40]. In Holland, the number of uninsured and delinquent payers (who had not paid premiums for over 6 months) went up sharply after 2006 to about 3 percent of the population (from an earlier base of about 1%) in spite of efforts to reduce those populations.

Four, both countries experienced an acceleration of market concentration in health insurance and health care. The numbers of independent health insurers went down, especially in Holland but also in Switzerland [41]. As Swiss insurers cannot contract selectively, Swiss hospitals felt less pressure than their Dutch counterparts to consolidate their market positions. Anticipating earlier health reforms of the late 1980s (even while those reforms were only partially implemented), Dutch hospitals, nursing homes, home care organizations and other providers engaged in processes of vertical and horizontal integration to strengthen their market positions [19]. The 2006 insurance mandate triggered an acceleration of that concentration trend, resulting in smaller numbers of bigger hospitals and multi-location hospital systems and long-term care facilities. In several regions, institutions offering inpatient and ambulatory mental care merged, in some cases creating virtual regional monopolies. Most Dutch family practitioners (GPs) as well as some other professionals, however, continued to work solo or in a small group practice. The 2006 health insurance legislation assumes that each hospital and every GP practice will negotiate with all health insurers on an individual base. Hospitals, as noted above, sought to strengthen their market position by merging with others. Only in a very few cases such mergers were blocked by the national competition authority. To overcome administrative fragmentation and reduce the administrative burden, Dutch GPs set up legal entities that serve as collective bargaining agencies in their region. Thus, while the 2006 “managed competition-reform” in The Netherlands aimed to create competitive markets where individual insurers were to selectively contract with individual health care providers, those actors effectively eliminated or reduced competition by strengthening their market positions, also reducing the need to engage in individual bargaining. The weakening of the centralized collective bargaining that characterized the former neo-corporatist system also eroded the cost control mechanisms (price and capacity

controls) at the central level. Organizational change took place, but not in the direction that the reformers had expected or hoped for.

Five, both Switzerland and The Netherlands are shifting towards care-based payment for hospital care (presented as an essential element in creating transparency about health care services), but in strikingly different ways. The development of case-based payments (in most countries labeled “diagnosis-related group” payment or DRGs) in Holland illustrates the need to compare countries’ reform processes in a detailed and disaggregated way before drawing general conclusions [42]. Rather than just copying the existing payment model of Australia or the United States, the Dutch government decided to take an idiosyncratic course in the 1990s. It encouraged medical specialists and local hospitals to develop case-based tariffs themselves, and to include detailed information about diagnoses, medical treatment and the use of different inputs for each category of patients, in the local setting. This decentralized process led to over 40,000 tariffs for “diagnosis-treatment combinations” (that covered less than 20 percent of all hospital activity in 2007). The implementation of this “home-grown”, very complicated and very expensive DRG-based hospital payment model slowed down, and in 2011 (as in 2007), government announced a drastic simplification but as of the writing of this article it is not yet clear what the final outcome will be.

Finally, it is important to note that the insurance mandates of Switzerland and Holland did not replace government planning and control. The current systems show an intricate overlap or “layering” of competing and sometimes conflicting governance models [43]. In both Switzerland and The Netherlands, the current health care system is less market-oriented than some experts claim, or some foreign observers seem to hope. While the policy rhetoric emphasizes market efficiency, less government and more consumer choice, the Swiss and Dutch governments actually expanded their role in monitoring and supervision of health care. For example, a new legislation to strengthen federal control over health insurers is under discussion in the Swiss Parliament and Cantons set up a new agency for health technology assessment as a base for defining entitlements. The Dutch Health Ministry continues to monitor and control health costs by setting global budgets, price controls and other measures. It has not reduced its active role in the development of health information technology, the development of case-based payments for hospitals and quality control – hardly, as some commentators claimed, a “hands-off approach with government’s role reduced to that of an umpire” [5].

4 Conclusions

Assessing the outcomes of health care reform requires first of all an accurate understanding of the current situation and of the assumptions underlying the policy change, including expectations of policy-makers about the behavioral changes of all the parties affected by the reforms and the final results. In assessing the health reform experience of Switzerland and The Netherlands, this article has highlighted three major gaps: one between the underlying assumptions of the model of managed competition and the actually implemented insurance reforms (in particular the assumptions about behavioral change of insurers, health care providers, patients and insured and governments); another gap between expectations and outcomes of the reforms (in particular expectations about cost control, efficiency and integrated care fueled by market pressure of active consumers in health care on competing insurers and competing health care providers) and the third gap between the experiences of Switzerland and Holland and the international commentary that depicts the two countries a successful beacons of “consumer-driven health care”, worth following by others (in particular the suggestion that in both countries, markets would replace the role of governments in allocating resources for health care in an efficient and consumer-friendly way).⁶

Models look appealing on paper, but they are difficult to implement as planned and during implementation—as in all fields of social policy—governments will face pressure of organized opposition groups to change and adjust their course. Swiss and Dutch health insurers, as well as Dutch hospitals and GPs—used strategies to defend and strengthen their market positions that in some cases all but defeated competition policies. The crucial assumptions of the “managed competition” or “consumer-driven health care” model are that concerning consumers will carefully select their health plan, and that (competing) insurers will negotiate contracts with (competing) providers who will feel pressure to offer good quality care at lower costs. The model thus has consumers “choosing” their providers via the insurance plan. But there is little evidence that Dutch insurers felt pressured by their insured to use their selective contracting power to improve the quality and patient-friendliness of care or to keep costs down after the introduction of “consumer-driven health care” [6].

In fact, market concentration became their preferred strategy. In both Switzerland and Holland, young and healthy employed persons were the main switchers, lured by lower premiums or supplemental coverage for non-essential services—not by better basic health care. The elderly, handicapped and chronic ill—the groups who need basic health care most—were the least likely to change plans. Some commentators have argued that even a modest degree of consumer exit may create effective competition (even as there is no agreement on what would count as a minimal critical mass). But if the exiting groups are not the relevant consumers, their exit does not create the desired or expected market pressure.

Finally, as we have argued elsewhere, both the Swiss and Dutch experiences confirm the need for “post-reform maintenance” [44]. Reforming complex health care systems is not a one-shot effort as unexpected and undesired outcomes may force governments to adjust their course. For example, the rise of numbers of uninsured and delinquent payers prompted government action, sometimes changing the rules of the game for certain categories of insured. In several cases, governments (partially) reinstated entitlements it had de-listed previously (for example, dental care in Holland or homeopathic medicine in Switzerland) after strong opposition. In both countries, certain categories of patients are exempt from user fees and governments imposed annual caps on the total amounts of user fees families have to pay. In Holland, the mandatory deductible does not apply to general practitioners, dental care for children or childbirth care. All those exemptions weaken or eliminate the role of “health care consumers” They illustrate the need for government action after implementing reforms that supposedly give the reins to non-government actors.

The Swiss and Dutch experiences with “consumer-driven health care” should prompt other jurisdiction to be careful in adapting this model. In fact, the “triple gap” mentioned above illustrates how ill-defined and hardly tested policy ideas or theoretical models travel faster around the world than accurate descriptions of reforms processes and critical assessments of outcomes. As Rudolf Klein once observed [45], we have to *learn about* the experience of others before we can *learn from* that experience—let alone try to transfer policy ideas without carefully assessing their operational feasibility and likelihood of success.

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Tables

Table 1: Health care expenditure per capita, selected countries, 1980-2010 (US\$ purchasing power parity)

	1980	1990	2000	2010
Canada	777.4	1735.3	2518.8	4444.9
France	667.3	1443.7	2544.8	3974.0
Germany	976.7	1798.1	2677.8	4338.4
Netherlands	733.1	1413.6	2340.3	5056.2
Switzerland	1032.6	2029.9	3221.5	5269.6
United States	1101.8	2850.7	4790.5	8232.9
OECD Average				

Source: OECD Health Data 2012

Table 2: Health care expenditure as share of gross domestic product, selected countries, 1980-2010 (% of GDP)

	1980	1990	1995	2000	2005	2010
Canada	7.0	8.9	9.0	8.8	9.8	11.4
France	7.0	8.4	10.4	10.1	11.2	11.6
Germany	8.4	8.3	10.1	10.4	10.8	11.6
Netherlands	7.4	8.0	8.3	8.0	9.8	12.0
Switzerland	7.4	8.2	9.6	10.2	11.2	11.4
United States	9.0	12.4	13.7	13.7	15.8	17.6
OECD Average						

Source: OECD Health Data 2012

¹ This contribution is partly based on Okma and Crivelli [46]

² There is a remarkable lack of knowledge of consumer preferences—few if any countries have asked citizens what type of health insurance or health care they prefer or need, in particular frail elderly or disabled or chronic ill patients—or whether they want to be the “drivers” of health care.

³ The more recent example of the difficulties to carry-out reforms in the Swiss health system is the outcome of the popular ballot held on June 17th 2012. In spite of a six-years long debate in Parliament that led to an almost balanced draft bill accepted by the majority of political parties, the FMH (the Swiss Medical Association) launched a referendum and was extremely successful in convincing the citizens that the new law would undermine patients’ free choice of physician. Indeed the new law was rejected by an overwhelming majority of voters (76%).

⁴ Obviously, changes in the composition of health care funding (say from social insurance to private insurance or out of pocket spending) have major distributional consequences [47].

⁵ The administration of the fiscal subsidy turned out to be complex and expensive—the Tax Department had to hire over 600 extra staff to calculate and adjust the monthly premium subsidy amounts of fiscal subsidy for all eligible insured.

⁶ This contribution does not consider changes in the health of Swiss or Dutch citizens as (potential) “outcome” of the health care reforms, for different reasons. The first is that the stated reform goals of the insurance mandates primarily aimed to improve quality and efficiency of health care services, and not directly aimed to improve population health. Second, changes in health status (e.g. measured as an increase in life expectancy or drop in child mortality) occur gradually over time. Third, such changes are as much associated with rising incomes, improved living and working conditions or life style changes as with explicit government policy. Both Switzerland and Holland are generally wealthy and healthy countries, and their reforms did not lead to major change in health indicators.