Interview: Daniel Schmutz – CEO, Helsana, Switzerland



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Daniel Schmutz, CEO of Switzerland's leading insurance company, Helsana, sketches out the Swiss health insurance landscape, how his company maintains its market leader position, and working with both national and international partners to create better products for its customers and a more efficient insurance system.

With 1.9 million policy takers and CHF 6 billion (USD 5.96 billion) in inland premiums, Helsana is one of the largest healthcare insurers in Switzerland. Could you start by introducing the healthcare insurance landscape here and where Helsana fits within that?

To describe the insurance landscape, it is necessary to first describe the system in general. The insurance landscape changed 21 years ago when we introduced the health insurance legislation, which by European standards is quite recent. It was only then that health insurance became mandatory in Switzerland. This fact led to a need to define what the benefits of that compulsory insurance would be.

As Switzerland is a relatively entrepreneurial country within Europe where decentralization is quite important, it was decided that the Cantons should play a large role in this system and that there should also be individual responsibility. In contrast to other countries, it is not the state that provides the coverage, but a mandatory insurance scheme. That is the first pillar of our business. The "basic insurance" package is defined by law and is quite comprehensive; allowing for example access to all kinds of pharmaceutical products, specialty treatments, and hospitals. However, there

are quite a few other options in these benefit packages. For example, you can choose deductibles as well as managed care models which give discounts to people who commit to behaving in a certain way, i.e. going to the same gatekeeper and purchasing the drugs through alternative channels. Freedom of movement, freedom of choice, and access are very important here and anyone, in any year, can go to a different insurance company. We cannot turn down anyone due to pre-existing conditions and there is community rated pricng. The Swiss system therefore is costly but of an excellent quality and without waiting periods.

The second part of our business is supplemental insurance. The regulator allows for top-up insurance on top of the basic, mandatory insurance. These products cover areas such as dental treatment, eyecare, and fitness. The supplemental hospital insurance products give you free choice of doctor in the case of hospitalization and better amenities such as a private room. That is an insurance business in the more traditional sense in that we can underwrite, risk-select – at least at the beginning – and work more like a “normal” insurance company.

Our third pillar is worker’s compensation and accident insurance which we do for corporations. Combining those three lines of business, we are the largest player in Switzerland and in basic insurance alone, we are number two.

The Swiss healthcare system is of an excellent quality but quite costly, with costs continuing to rise. From a payer’s perspective, what do you see as the main drivers of this?

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The system here, although it has many elements of individual responsibility compared to other European nations, is by no means a market system. There are many regulations and protectionist legislation which lead to the fact that we pay a high price for healthcare. In healthcare, you are always going to have an interaction between regulatory mechanisms and private sector activity; if you leave healthcare to market forces alone, you end up with a mess. However, we do see incentive structures that are simply outdated. As an example: as soon as you qualify as a doctor here, you know that you have access to the entire patient population of Switzerland and do not have to worry about contracts. That is not helpful when you want to negotiate prices.

There is quite a stable cost-per-treatment trend, but the issue is volume. People want more, there are more providers, therefore there is more volume. Obviously, that has to do with our consumer patterns. An MRI is completely standard treatment now for patients that would have been given an X-ray 10 years ago! Another example is physiotherapy, which has become standard practice after

operations. People have already paid for the service in their premiums so will obviously choose to do it. As we still have some elements that protect the provider side, and a population that is used to not having to wait to get access, you get volume increases.

The other side is prices; Switzerland has high prices for everything! I can see the case for highly innovative drugs being highly priced, but there is no reason why generics should be significantly more expensive here than anywhere else. If you reduced generics to a European price, we would get about CHF 3-4 hundred million (USD 2.9-3.9 hundred million) back from healthcare costs. What has changed in the last two years is the public's awareness that we do in fact have a cost problem. However, we have had three votes on moving from multiple payers to one single, centralized government, per Canton or nationwide in the last 15 years which were all voted down. We also had votes on increasing managed care, which was also voted down because it was feared that it would reduce free access to specialists. We had a vote on including homeopathics in the basic insurance package which was voted in favor by a large margin.

When push comes to shove, the Swiss people still favor additional benefits versus costs. In Switzerland healthcare costs are rising, but in terms of percentage of GDP, these costs have actually grown more slowly than in other countries, albeit from a relatively high starting point – we are seventh in OECD. The big difference between Switzerland and the other countries around us in that ranking (Canada, France, Switzerland, Denmark, the Netherlands) is that here, the cost is very visible to the consumer. In France, you might pay 50% of your salary in taxes, part of which covers healthcare. There are deficits. In Switzerland, that is not possible; if we make deficits we go out of business. The system is deficit-free but its true costs are factored so you see the increase every year, and as a family you pay it from your pocket.

I think that mainstream journalism has now caught on. Reform is still slow and we still have a system where, hospitals are controlled by individual Cantons and for example, some Cantons are trying to separate the assets and create independent holding companies for the hospitals. Other Cantons are still holding onto that infrastructure and also investing public money in it. As an example, the Canton of St. Gallen covers an area where in England you would have one NHS hospital, but in fact hosts six hospitals with close to a billion CHF (USD 0.9 billion) being poured into them. For a country of our size, to have 300 hospitals is too many. When I went to Denmark three years ago, they had 40 and had plans to reduce that to 25.

Helsana started its own in-house scientific health service research center in 2011, which has been producing reports ever since. What was the logic behind setting up this center?

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We are committed to moving from being a payer to being a player. I firmly believe that it is important that we use information to the benefit of our customers. We have been trying different ways to make information in our field more transparent and digestible; the reports are one way of doing so, as they are geared towards the provider system itself. Previously, Swiss doctors knew how diabetics were being treated in Switzerland but did not have any view on how it is done globally. One of our reports therefore looked at how diabetes is being treated in Switzerland and found that diabetic patients are far better off in a managed care setting, which is also much more cost effective.

Another initiative in that field is what we call *Gesundheitskompetenz*, which is a way of trying to make information available for patients for individual healthcare decisions. We still say that the customer should decide themselves which treatment to take. Freedom of choice is a very important feature in Switzerland in general and in healthcare specifically.

How can this type of data be useful at national and Canton levels in Switzerland and in other markets?

We are trying to get the message out and have had interesting discussions with Cantonal delegations. Switzerland is a small country and everyone tends to know everyone. Decision making is therefore collaborative. Helsana has a large market share but on our own we cannot and do not want to force the providers to do anything. The system emphasizes freedom of choice, so we share our findings to influence outcomes nationally as well as internationally. Through the International Federation of Health Plans (IFHP) the barriers to cross-border information exchange are low. It does not matter if health insurers in Australia hear what we have done successfully and copy it as we do not infringe on each other’s territories.

Can you give any specific examples of how your findings have provoked a reaction in terms of reforming or changing the system?

There are two kinds of impacts: on the systemic level and the more tangible, operational level. In terms of cost growth, one area where we don’t have growing costs for old-age care. There were some proposals on the table which would have put that cost as additional on top of basic insurance but, also due to our data and findings; the decision was made to implement a more predictable model We prevented something bad from happening for our premium payers and we therefore help people make their own better informed decisions.

Another project I would like to highlight is a more recent one. The way the system is organized with free access to specialists, many people with multiple illnesses go to multiple specialists. What often happens to them is that they end up with a cocktail of medicines that they actually should not be taking together. Together with an innovative start up from ETH, we created a software which shows the doctor if there is a danger of a risky cocktail. This is now being rolled out and is an example of us using our data to try and influence outcomes; not on a systemic level but on a real for-patient level. That is what I meant by becoming a player and becoming relevant for the client.

Helsana has also been instrumental in setting up a new association of health insurers, Curafutura. What was the rationale behind that?

The healthcare insurance landscape in Switzerland is quite diverse. We have over 40 independent outfits, many of which are quite small. Back in the days when we had only one association, it was very difficult to form a common opinion. The divergent interests lead to the fact that it had little impact. We decided that it was better to have a more focused association that does not represent 100% of the market but actually groups players who, at least on a philosophical level, share some of the same views. This has been mutually beneficial as both associations now know that if they do not perform, their members can choose to leave have choice. Both associations have become more effective; providing a classic example of how competition also works in the political field.

With 40 or so other health insurance companies in the Swiss market, how does Helsana differentiate itself?

As the basic insurance is the same, you can try to differentiate on price, but that only works in the long run if you aggressively risk-select. We have a different strategy focused on customer-centricity.

We try to emphasize customer engagement and differentiate ourselves in supplemental insurance and on a product level where we have products that others do not. You can also differentiate yourself on service, friendliness, and additional services. Price is a dominant factor and every year you have anything from 6-10% of the population that switch insurance company, which is very high. It is a very competitive market out there!

In terms of your corporate strategy, you set the date of the end of 2018 to break into the Top Three in terms of net promotor score (NPS). What is your blueprint for ensuring that you meet that goal?

We have a clear execution plan. Our activities are bundled into groups with allocated responsibilities and resources but my contribution is more important on a cultural level – this is a strategy that does not work if it does not work for the 3,000 employees of our company. At the outset of the strategy, we started not by defining our goals but defining why we exist. We engage for your life. That “life” rather than “health” is deliberate; it is not that we want to be a life insurance company, but we want to make a difference not only for your health, but we want to make your life easier. We translate that into values and we set goals.

Through a strong investment in our back office capabilities and IT, we are moving towards becoming a more efficient, modern, digitally-based company. It needs to come together at the client – it is not about what we do but what the customer feels. We realize there that it takes a long time to change perceptions. There you have a disadvantage in being big – we are seen as a dominant player so it is harder to be liked! But on the other hand, our scale also gives us advantages, allowing us to have more operations arms. This is a struggle that we have not finished. I am a strong believer in setting ambitious goals in terms of timing rather than setting too long time frames at the outset and losing focus.

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