The Swiss Health Care System

Dr. Abdo Jurjus
President, Lebanese Health society

Preamble

The Swiss healthcare system upholds the principles of universality and equality by mandating individuals to purchase health insurance on the private market, providing financial assistance to those on lower incomes and regulating the insurance market in order to protect those with poor health. The result appears to be high quality care for all, excellent patient satisfaction, strong uptake of new technology and drugs, short waiting lists and impressive health care outcomes. This has led to an increasing number of admirers and even exportation of the system to other countries. A high-profile example of this transfer process is the US, where economist Paul Krugman has described the Obama healthcare reforms as "a plan to Swissify America, using regulation and subsidies to ensure universal coverage", noting that this will be a "vast improvement" on the existing US system. Some admirers of the Swiss system have specifically noted the relatively low public expenditure in the Swiss system compared to much of the developed world. OECD figures suggest that 65.2 per cent of health spending in Switzerland is public, somewhat below the OECD average of 72.2 per cent and well below the UK figure (83 per cent), demonstrating that a relatively large proportion of private spending can still be compatible with high-quality, universal government-backed care under the right conditions.

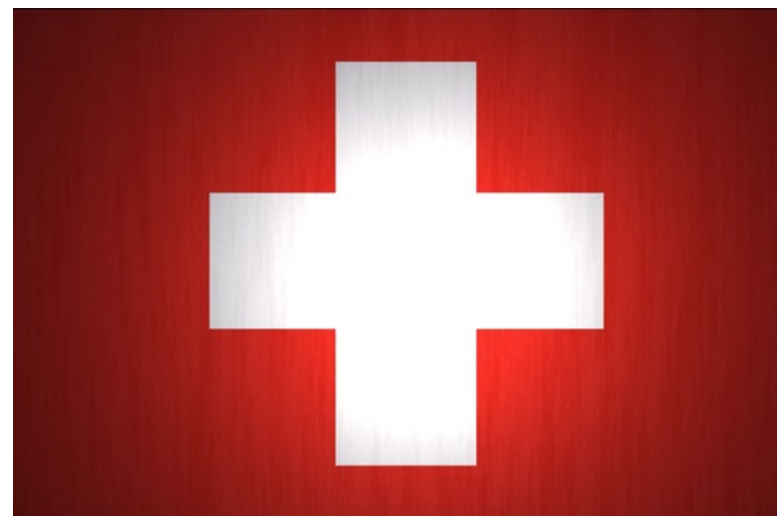
Overview

The current Swiss healthcare system came into effect in 1996 under the Health Insurance Law (LAMal) of 18 March 1994, which sought to "introduce a perfect managed competition scheme across Switzerland, with full coverage in basic health insurance". The LAMal made this 'basic package'– defined by the Swiss federal government and regulated by the Federal Office of Public Health – compulsory across the Swiss confederation. The idea behind this new law was to define the level of health care that patients may expect as given, but allow competition between insurers to drive up standards and drive down the cost of the insurance premiums. In order to avoid discrimination, insurers must accept all applicants ('open enrolment') and cannot vary premiums based on the health of each consumer; nor can they make a profit on basic package plans. Beyond the basic package individuals are still allowed to purchase supplementary insurance to fund any additional health care.

The Swiss system is highly decentralized, meaning that the 26 Swiss cantons are largely responsible for the provision of health care and insurance companies operate primarily on a regional basis. Meanwhile, the role of national government is restricted by the constitution to one largely of public health and regulation.

The 'basic package' Care System

The basic package is restricted to medical treatment deemed appropriate, medically effective and cost effective. Individuals can only seek treatment in their canton of residency and may not be treated in hospitals that aren't accredited to receive reimbursement for providing 'basic treatment.' This inevitably cuts back on choice, but is seen as a necessary cost-saving measure.



The 'basic' package is in fact very extensive and has expanded over time. It is divided into three categories: Sickness Insurance, Maternity Insurance and Accident Insurance and below are some examples of the treatment covered:

* Hospital stay and outpatient care in any general ward of the canton of residency;
* Nursing care, of up to 60 hours per week at home or in a nursing home;
* Examination, treatment and nursing in a patient's home by a physician or chiropractor;
* Rehabilitation ordered by a physician, including health resorts;
* Physiotherapy and ergotherapy (max. 9 sessions);
* Nutritionist/diabetic consultation (max. 6 sessions);
* Emergency treatment abroad;
* Transportation and rescue costs (50% of emergency transport costs up to CHF 5,000 per year and 50% of non-life threatening transport up to CHF 500 per year);
* Legal abortion;
* Maternity costs, including 7 routine examinations, post-natal examination, childbirth and 3 breast-feeding consultations;
* Serious and inevitable dental treatment;
* Contribution to spectacles and contact lenses of CHF180 per year for children and CHF 180 over 5 years for adults.
* Complementary medicines (alternative and homeopathic remedies)

Universal Coverage

A number of provisions attached to the basic package ensure that "vulnerable groups have good access to healthcare," thus maintaining the principle of universality:

* All individuals must purchase a basic package insurance plan or face a penalty.
* Insurers must charge the same price to every individual that buys a particular health care plan: in other words they cannot vary premiums based on the health status of each consumer. To ensure that insurers abide this rule a risk equalisation solidarity body called 'Foundation 18' (named after the law that created it) redistributes funds from those health plans with lower health risks to those with higher, based on the age and sex of enrolees.
* Individual cantons provide tax-financed, means-tested subsidies directly to those unable to afford basic package premiums (not to the insurer). According to the Federal Office of Public Health (FOPH) 30.5 per cent of insured individuals required this financial assistance in 2009.

So long as a health plan meets the requirements of the basic package and insurers don't risk selection, insurance companies are allowed to compete on price.

Managed Care Organizations (MCOs)

Insurers can offer health plans that employ MCOs to cut costs by reducing the patient's choice of health care provider: an option chosen by 12% of enrolees in 2007. A health insurance policy run by an MCO will selectively contract providers – quite often their own self-financed medical centres. Most will also use 'physician networks' with general practitioners (GPs) acting as 'gatekeepers'. Outside of MCOs individuals can choose from 'any willing provider' within their canton and can self-refer to specialists.

Supplementary Insurance

Supplementary insurance is voluntary and refers to health care beyond the scope of the basic package. There is no obligation on the part of individuals to purchase it, although many in Switzerland do, and the provisions attached to the basic package don't apply here: the market is regulated by the Federal Office of Private Insurance (FOPI) but the Office does not prevent companies from charging higher premiums to those individuals they deem to be of higher health risk.

Provision

The provision of healthcare, (hospital services in particular) is generally organized at the cantonal level, although the Federal authority maintains some oversight. For example, the National Association for Promotion of Quality in Health Care is charged with managing and monitoring provision and health care professionals can enroll in Federal and Cantonal Medical Associations.

Primary Care

Primary care providers are funded through reimbursement from insurers and primarily consist of independent practices of GPs and specialists. Although most individuals register with a permanent GP in a particular hospital unit or polyclinic, individuals not in a managed care plan have the freedom to choose between all primary care providers in a given canton and doctors are paid by insurers on a 'fee-for-service' basis for services encompassed by the basic package. All doctors are required to inform patients which services their basic package covers and which they must purchase supplementary insurance for or pay out-of-pocket to receive.

Secondary and Tertiary Care

Unlike primary care, cantons have extensive authority over the hospital sector. Cantons are responsible for planning the provision of services according to local needs, negotiating uniform prices for medical treatment (payable by insurers to providers) and compiling a list of hospitals eligible for reimbursement of 'basic treatments'. This decentralised authority means that hospital provision varies hugely across Switzerland because cantonal objectives differ in terms of focus on delivering high quality services, ensuring cost-efficiency and curbing excess capacity.

Currently hospitals are paid by a nationwide Diagnosis Related Group (DRG) system which, instead of paying using a traditional fee-for-service model, remunerates hospitals on a case basis.

'Big Issues'

Despite its undeniable effectiveness in terms of health outcomes, there is, as always, a fairly consistent debate about how to achieve the familiar triumvirate of objectives when it comes to healthcare systems: equitable access, high quality and low cost:

Key areas of concern within the system:

* Affordability: Concomitant with health expenditure climbing to 11.4 per cent of GDP over the last decade, 'basic package' premiums have increased by an average of 5% per year and out-of-pocket expenditure is high compared with the OECD average.
* Comprehensiveness of basic package: Many argue that costs are escalating predominantly because the basic package has become too comprehensive.
* Restricted choice: At the most basic level, choice is restricted through cantonal hospital lists.
* Fragmentation: There is some concern about the inefficiencies spawned by the decentralized nature of the Swiss healthcare system. The OECD recently concluded for example that one of the principle reasons for which the Swiss system suffers from "regulatory problems" is that the cantonal structure somewhat undermines attempts to create national standards in health care.

Lessons

The facts and figures associated with the Swiss healthcare system show a system that consistently produces some of the best health outcomes and patient satisfaction in the world (see Statfile below). As a nation they have achieved universal health coverage whilst avoiding substantial regional health inequalities and ensuring that everyone has good access to top quality and high-tech medical services. The question therefore is how have they achieved this and what price did they pay for it?
It is undeniable that health care costs and expenditure in Switzerland are quite high – the Swiss spend 11.4 per cent of their GDP on health compared with the OECD average of 9.5 and health spending per capita is even further above the OECD average at US$ 5144ppp (OECD average = US$ 3223ppp).

In conclusion, there are many aspects of consumer driven and private market-based health care that are effective in producing good health care outcomes and high patient satisfaction. Providing those on low-incomes with enough money to purchase health insurance in the same way that everyone else does is also a much more effective system than the "two tier" approach of America where those on Medicaid are often treated differently by providers who know they will not be adequately reimbursed for their services.

Statfile (most recent figures from the OECD unless otherwise stated, and OECD average given for comparison)

Funding

Total health expenditure (% GDP): 11.5% (OECD Average: 9.5%)
$5489 per person (US $, adjusted for PPP) (OECD Average: $3265)
Total public expenditure (% total health expenditure): 65.2% (OECD Average: 72.2%)
Total out-of-pocket expenditure (% total health expenditure): 25.1% (OECD Average: 19.5%)

Consumer Powerhouse Index

The Swiss healthcare system ranked fourth in the 2007 Euro Health Consumer Index (EHCI), which compares European healthcare systems from consumers' point of view on the basis of 27 criteria including: waiting times, pharmaceutical availability and quality of services. Switzerland scored particularly highly on waiting times and health outcomes; being concerned particularly with the opinion of consumers, that Switzerland came fourth out of 26 countries surveyed clearly demonstrates high consumer satisfaction. This is consistent with previous surveys, such as that by Coulter and Cleary in 2001, which ranked the Swiss system the highest on patient satisfaction.

Process Outcomes

Practicing physicians (per 1,000 population): 3.8 (OECD Average: 3.1)
Practicing nurses (per 1,000 population): 16 (OECD Average: 8.6)
MRI scanners (per 1m population): 17.8 (OECD Average: 12.5)
CT scanners (per 1m population): 33.7 (OECD Average: 22.6)

Waiting Times

Percentage waiting four weeks or more for a specialist appointment (study of 11 OECD nations): 18%, 2nd lowest out of 11 (Average: 37%)
Percentage waiting four months or more for elective surgery (study of 11 OECD nations): 7%, 3rd lowest out of 11 (Average: 13.3%)

Health outcomes

Average life expectancy (at birth): 82.6 (OECD Average: 79.8)
• Men: 80.3 (OECD Average: 77.0)
• Women: 84.9 (OECD Average: 82.5)

Infant mortality rate (per 1,000 live births): 3.8 (OECD Average: 4.3)
Maternal mortality rates: 7 (2006) 8.282
Mortality rate from cancer: 180 199 (2011)
Mortality rate from ischemic heart disease: 88 110 (2011)
Mortality rate from stroke: 29 42 (2011)