Switzerland: The Health Care System

The health care system in Switzerland is consistent with the long-standing national sentiment of allowing state activity ‘only when private initiative fails to produce satisfactory results.’ The system is largely consumer driven, with a combination of public and private efforts. Switzerland operates the second most expensive health care system behind the United States, with health care expenditure totaling 11.3% of the GDP. The federal government provides oversight to the system, and 23 cantons are responsible for regulation and financing of the public delivery system. Public expenditure is among the lowest in Europe, at about 60% of total contributions.

A national mandate requires every person to individually purchase health insurance. Consumers can choose from about 100 public and private insurers, all of which are required by law to be not-for-profit. Insurers must offer a basic package of comprehensive benefits, and are obliged to accept all applicants. The nationally standardized set of services must meet criteria of both clinical and cost effectiveness. The insurers vary in size from 2,000 members to well over one million. Insurance is not employer based but many plans are grouped on varying levels; national, regional, religious, and occupational plans are common. A clause named Foundation 18 also establishes a risk-adjustment scheme between insurers to support plans attracting higher-risk individuals.

Plans cannot compete through benefit packages, but rather via premiums and deductible pricing. These prices may vary considerably between cantons, as they are community-rated (prior to 1996 premiums were risk-related).

The national average cost is about $2,500-2,900 per individual annually, with much lower premiums for those under 25 years old. Federal subsidies are granted to persons whose premiums comprise more than 8-10% of annual income. About 30% of the population receives this benefit. Deductible options also lower premium rates, with discounts up to 40% for high deductibles. User fees are also present for most medical care and are capped at about $600 per year.

HMO-type policies have also emerged, offering lower premiums (10-20% reduction) for more restricted provider choice. Smaller regional plans have also developed general practitioner physician networks to act as gatekeepers, which allow 5-15% reduction in premium prices. 25-40% of the
population also elects to purchase supplementary insurance to cover dental care and other amenities like private hospital rooms.

Individuals generally have unlimited free choice of providers, though almost all have a regular physician. Doctors are mostly private and office-based, operating in a fee-for-service structure. All prices are negotiated at the cantonal level. Hospital and outpatient care can be either private (managed as for-profit or not-for-profit) or publicly based. Cantons subsidize 50% of operating costs for public and non-profit hospitals. Insurers and hospitals may also contract directly with physicians, and they are typically paid through a salary. Insurers are not allowed to negotiate preferred provider contracts with hospitals in return for lower fees, thus restraining hospital price competition.

With the most expensive system outside of the United States, criticism is aimed at high costs and the need for more cost-effective delivery. Switzerland has the second highest (to the US) utilization of cutting-edge technology. Little negative financial incentive for utilization combined with a high density of providers results in an average 11 doctor contacts per person per year; the highest in Western Europe and nearly three times the US rate. A majority of doctors are paid via fee-for-service, which drives up utilization and cost, in addition to a general lack of less expensive ‘non-doctor’ care. Respected local economists are suggesting greater price competition between providers and purchasers, which they believe will improve efficiency.¹ To decrease costs, insurers are also hoping to thin the standard package of benefits by more critically determining the real health benefits for certain services. Global budgeting for hospitals operating subsidies is now in place in several cantons and may spread to more; this may also help to stem rising expenditures. There is also a lack of comparative statistical data, which could promote benchmarks in quality and efficiency. The combination of universal care through an individual mandate with subsidies and insurers’ price competition guarantees every Swiss citizen high quality, readily accessible care. Targeting system-wide inefficiencies (over-supplied and over-utilized) will aid in reducing total expenditure.

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Resources:

¹ Zweifel, presentation to the Health Policy Reform Group, 2001