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Healthcare in Switzerland

The healthcare system in Switzerland is a complex combination of public care, subsidised private and wholly privatised healthcare. The share of public spending, however, is one of Europe's lowest – reflecting the fact that Swiss law earmarks the State's role as a healthcare guarantor only when the private sector "fails to produce satisfactory results". Not surprisingly, on a per capita basis, Switzerland operates the world's third most expensive healthcare system – behind the US and Germany.

Switzerland's healthcare system also reflects the country's confederal State. Consequently, its 26 local governments have strong powers (see box). They are responsible for hospital regulations (including accreditation) and finance, as well as preventive health.

There is, however, a uniquely Swiss element within the healthcare system. Switzerland provides power not only to the local Cantons, but also to individuals - as borne out by its seemingly constant succession of referenda. As a result, Swiss citizens play a direct role in the healthcare system, for example by voting to expand hospitals.

The public healthcare system in Switzerland is largely based on the mainstream northern European model, principally in terms of 'fund pooling' – by virtue of which individual payments are collected by one or several insurance /sickness funds, and grouped together (pooled). Healthcare expenditures are then paid out of it. Subsidised private care in Switzerland generally includes at-home paramedical services during pregnancy, after accidents and for the elderly (including nursing homes). Fully private care, on the other hand, involves treatment by doctors in private practice, at private clinics, and is far closer to the US model.

Healthcare in Switzerland is regulated by the Federal Health Insurance Act. Health insurance is compulsory for all persons resident in the country and covers a range of treatments. These are listed and described in considerable detail within the Federal Act so as to provide similar standards of healthcare throughout the country.

On their part, insurance companies cannot prescribe conditions or vary premiums on their compulsory policies – on the

grounds of age, gender or health status. However, this does not apply to complementary insurance, where premiums are riskbased.

Insured persons retain full freedom of choice among recognised treatment providers. Costs of treatment and hospitalisation are covered by their insurance firm up to the level of the official tariff. The balance is borne personally through an annual 'franchise' ranging from CHF 300 to CHF 2,500, and by a direct charge of 10% of the extra costs. Insurance premiums depend on the insurance company, the chosen level of 'franchise', the insured person's place of residence and the degree of complementary benefits sought – for example, access to private wards in hospitals, dental care etc. In spite of Switzerland's wealth and the fact that the State specifies no limits on healthcare spending, there are challenges on the horizon.

Since 1995, the monthly premium for compulsory health insurance has increased by over 75%, outstripping inflation and a rise in the cost of living index by a factor of 10. One third of the Swiss population is already eligible for public subsidies for compulsory insurance, and this proportion is growing.

In the face of this, there is a small – but growing – presence of cost-containment and efficiency elements, principally in the shape of HMO-style managed care solutions, which began in Zurich and Basel in the early 1990s. Switzerland was in fact among Europe's pioneers in the introduction of managed care as an alternative to the more orthodox fee-for-service plans. However, the share of the former remains small, below 10%, largely as it lacks US-style incentives to restrict consumption of healthcare services. Nonetheless, managed care is estimated to have resulted in cost savings of 10–25% as compared with the traditional fee-for-service systems.

Switzerland's principal social health insurers now all have HMO divisions. There also are a handful of physician-owned HMOs. Premiums for HMOs are 10-20% lower than those for standard policies.

A derivative of the above is the so-called GP Physician Network, which exist in many smaller cities. Here general practitioners act as gatekeepers for insurers with the aim of preventing unnecessary hospitalisations. The participant physicians share in profits and losses, with an annual cap on the latter of CHF 10,000 per physician. Premiums for GP Physician Network insurance policy holders are roughly 10-15% lower than standard policies.

While these managed care initiatives have served to cap a growth in hospitalisation, they are, as mentioned previously, devoid of the powers of their HMO counterparts in the US. There is no provision, for example, to set up preferred provider contracts on the basis of negotiated prices with hospitals.

This is a direct result of the more consensual 'European' elements in Swiss politics and culture. The authority for healthcare service provision contracts rests with the Cantons – and their intensely political parliaments – rather than with managers of public hospitals. Swiss law specifies that cantons must cover 50% of hospital costs, and compile lists of approved hospitals with which insurers have to contract.

More radical reforms to healthcare financing services were envisaged in summer 2005 by the federal Committee for Social Security and Health of the Council of States. It has however been shelved for the moment, after intense opposition by the Cantons – and the threat of a referendum. The key element of these reforms was to move to unitary financing of healthcare services, with a single final purchaser in the shape of the insurance firms. Public contributions would be paid directly to the health insurers and anchored within the matrix of basic health services. On their part, rather than providing a subsidy for services offered by public hospitals or for at-home care, the Cantons would be required to pay a contribution determined in terms of a fixed percentage of all services covered by basic health insurance.

At the present moment, the federal government is scheduled to present a new legislative bill to Parliament by the end of 2008.

Direct Democracy and Health Policy

Well-known for its referendums, Switzerland is a living example of 'direct' rather than 'representative' democracy. The country's healthcare system is also unique in giving a great deal of power to local governments.

At the highest level, the Swiss Confederation is led by the Federal Council, which consists of seven ministers of equal rank. They are individually elected by Parliament for a period of four years. One is elected every year to be President of the Confederation. The job of the Presidency, however, does not provide any additional powers. The Parliament consists of two chambers. The 200-member National Council represents the population as a whole. It is elected for a term of four years, with seats distributed according to the votes received by different parties.

The Council of States has 46 members and represents the cantons. Every Canton, notwithstanding its population, is entitled to elect two members. There are 23 Cantons, of which three are split further into two autonomous sub- Cantons each. The Cantons have their own constitution, parliament and laws, and are sovereign in all matters not specifically designated the responsibility of the Confederation by the Swiss Constitution.

In the healthcare area, the Federal Council has delegated powers of implementation to the Cantons. Given below are the principal areas of Cantonal authority in healthcare.

Regulation of Healthcare

Ó Licensing of health professionals

Ó Authorisation to open a medical practice

Ó Authorisation to open a pharmacy

Ó Market authorisation for medicines (via the Intercantonal Union for the Control of Medicines

Provision of Health Care

Ó Inpatient care: Most Cantons operate their own hospitals, and some subsidise private hospitals. Many have begun to use global budgets since the mid-1990s, although implementation systems vary between

Cantons

Ó Nursing and home care

Ó Fees: Each Canton endorses fees negotiated between service providers and health insurance funds

Ó Basic and specialty medical training, paramedical training and oversight

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